

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-1348	I	FROM 7/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
					I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT

DATE: 11/25/2008 TIME 18:30

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:

RED BUD REGIONAL HOSPITAL 14-1348
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION

DATE: 11/25/2008 TIME 18:30

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PI ENCRYPTION INFORMATION

DATE: 11/25/2008 TIME 18:30

on68RyUVyQNo3Sxao6nffXPddb.Um0
2qo030efe71cpGBEJBji1BoZsee1ME
wQm.50.wkq0NSqjN_____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)_____
TITLE_____
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX
	1	A 2		B 3	4
1	HOSPITAL	0	-238,931	-333,442	0
3	SWING BED - SNF	0	-251,985	0	0
7	HOSPITAL-BASED HHA	0	0	-43	0
100	TOTAL	0	-490,916	-333,485	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Health Financial Systems	MCRIF32	FOR RED BUD REGIONAL HOSPITAL	IN LIEU OF FORM CMS-2552-96 (05/2008)
HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	I	PROVIDER NO: 14-1348	I PERIOD: 7/ 1/2007 I PREPARED 11/25/2008 I FROM 7/ 1/2007 I WORKSHEET S-2 I TO 6/30/2008 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: ST. CLEMENT BLVD	P.O. BOX:	
1.01 CITY: RED BUD	STATE: IL	ZIP CODE: 62278- COUNTY: RANDOLPH

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;				PAYMENT SYSTEM (P,T,O OR N)		
COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	V	XVIII XIX
0	1	2	2.01	3	4	5 6
02.00 HOSPITAL	RED BUD REGIONAL HOSPITAL	14-1348		7/ 1/2005	N	O P
04.00 SWING BED - SNF	RED BUD HOSPITAL	14-2348		8/10/2005	N	O N
09.00 HOSPITAL-BASED HHA	RED BUD HOME CARE	14-7486		11/22/1989	N	P N

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 7/ 1/2007	TO: 6/30/2008	1	2
18	TYPE OF CONTROL			4	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1
20	SUBPROVIDER	

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.		
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106?	N	
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).		
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	Y
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2	
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2	
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO.	N	
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N	
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N	
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.	/ /	/ /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.	/ /	/ /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.	/ /	/ /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.	/ /	/ /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.	/ /	/ /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.	/ /	/ /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.	/ /	/ /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION IN COL. 3.		/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3.		/ /
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N	
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	N	
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.		
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N	
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N	
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	N	N

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	N	N
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /		
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /		
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	7/ 1/2005
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02		
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1 0	2 0.0000
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	3 0.00	4 0
A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)			
28.03	STAFFING	%	Y/N
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	
28.07		0.00%	
28.08		0.00%	
28.09		0.00%	
28.10		0.00%	
28.11		0.00%	
28.12		0.00%	
28.13		0.00%	
28.14		0.00%	
28.15		0.00%	
28.16		0.00%	
28.17		0.00%	
28.18		0.00%	
28.19		0.00%	
28.20		0.00%	
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N	
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y	
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N	
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N	
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N	
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N	
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
MISCELLANEOUS COST REPORT INFORMATION			
32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N	
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N	
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N	
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL			
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	V	XVIII XIX
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE	1 N	2 N
		3 N	

WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?
TITLE XIX INPATIENT SERVICES
38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N
38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N
40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y 449008
40.01 NAME: COMMUNITY HEALTH SYSTEMS FI/CONTRACTOR NAME
40.02 STREET: 4000 MERIDIAN BLVD P.O. BOX:
40.03 CITY: FRANKLIN STATE: TN ZIP CODE: 37067-
41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	ASC	RADIOLOGY	DIAGNOSTIC
47.00 HOSPITAL	1	2	3	4	5
50.00 HHA	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
PREMIUMS: 115,549
PAID LOSSES: 273,712
AND/OR SELF INSURANCE: 0
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N
58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
56.01		N	0.00		0
56.02			0.00		0
56.03			0.00		0

Health Financial Systems	MCRIF32	FOR RED BUD REGIONAL HOSPITAL	IN LIEU OF FORM CMS-2552-96 (05/2008) CONTD		
		I	PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
HOSPITAL & HOSPITAL HEALTH CARE COMPLEX		I	14-1348	I FROM 7/ 1/2007	I WORKSHEET S-2
IDENTIFICATION DATA		I		I TO 6/30/2008	I

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).

0

MULTICAMPUS

61.00 DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER "Y" FOR YES AND "N" FOR NO. N

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	-----	-----	----	-----	----	-----
62.00						0.00
62.01						0.00
62.02						0.00
62.03						0.00
62.04						0.00
62.05						0.00
62.06						0.00
62.07						0.00
62.08						0.00
62.09						0.00

COMPONENT		NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	25	9,150	78,384.00		2,316		143
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					2,717		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,150	78,384.00		5,033		143
12	TOTAL	25	9,150	78,384.00		5,033		143
13	RPCH VISITS							
18	HOME HEALTH AGENCY					7,620		
24	RHC							
25	TOTAL	25						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

COMPONENT		TITLE XIX OBSERVATION ADMITTED 5.01	I/P DAYS / NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION ADMITTED 6.01	DISCHARGES TITLE XVIII NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			3,277				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			2,717				
4	ADULTS & PED-SB NF			222				
5	TOTAL ADULTS AND PEDS			6,216				
12	TOTAL			6,216				
13	RPCH VISITS							
18	HOME HEALTH AGENCY			9,621				
24	RHC							
25	TOTAL							
26	OBSERVATION BED DAYS			44	1	43		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

COMPONENT		I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					661	66	1,089
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		139.48			661	66	1,089
13	RPCH VISITS							
18	HOME HEALTH AGENCY		13.20					
24	RHC							
25	TOTAL		152.68					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
SALARIES							
1	TOTAL SALARY	7,597,333		7,597,333			
2	NON-PHYSICIAN ANESTHETIST PART A						
3	NON-PHYSICIAN ANESTHETIST PART B						
4	PHYSICIAN - PART A						
4.01	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5	PHYSICIAN - PART B						
5.01	NON-PHYSICIAN - PART B						
6	INTERNS & RESIDENTS (APPRVD)						
6.01	CONTRACT SERVICES, I&R						
7	HOME OFFICE PERSONNEL						
8	SNF						
8.01	EXCLUDED AREA SALARIES	653,679	246,337	900,016			
OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR:						
9.01	PHARMACY SERVICES UNDER CONTRACT						
9.02	LABORATORY SERVICES UNDER CONTRACT						
9.03	MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10	CONTRACT LABOR: PHYS PART A						
10.01	TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11	HOME OFFICE SALARIES & WAGE RELATED COSTS						
12	HOME OFFICE: PHYS PART A						
12.01	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE RELATED COSTS							
13	WAGE-RELATED COSTS (CORE)						CMS 339
14	WAGE-RELATED COSTS (OTHER)						CMS 339
15	EXCLUDED AREAS						CMS 339
16	NON-PHYS ANESTHETIST PART A						CMS 339
17	NON-PHYS ANESTHETIST PART B						CMS 339
18	PHYSICIAN PART A						CMS 339
18.01	PART A TEACHING PHYSICIANS						CMS 339
19	PHYSICIAN PART B						CMS 339
19.01	WAGE-RELATED COSTS (RHC/FQHC)						CMS 339
20	INTERNS & RESIDENTS (APPRVD)						CMS 339
OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	106,215	-32,735	73,480			
22	ADMINISTRATIVE & GENERAL	1,822,034	-788,156	1,033,878			
22.01	A & G UNDER CONTRACT						
23	MAINTENANCE & REPAIRS						
24	OPERATION OF PLANT	170,254	-38,001	132,253			
25	LAUNDRY & LINEN SERVICE	201		201			
26	HOUSEKEEPING	154,519	-13,968	140,551			
26.01	HOUSEKEEPING UNDER CONTRACT						
27	DIETARY	151		151			
27.01	DIETARY UNDER CONTRACT						
28	CAFETERIA						
29	MAINTENANCE OF PERSONNEL						
30	NURSING ADMINISTRATION	594,891	-45,015	549,876			
31	CENTRAL SERVICE AND SUPPLY	32,538		32,538			
32	PHARMACY	207,491		207,491			
33	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	189,357	-9,569	179,788			
34	SOCIAL SERVICE						
35	OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY							
1	NET SALARIES	7,597,333		7,597,333			
2	EXCLUDED AREA SALARIES	653,679	246,337	900,016			
3	SUBTOTAL SALARIES	6,943,654	-246,337	6,697,317			
4	SUBTOTAL OTHER WAGES & RELATED COSTS						
5	SUBTOTAL WAGE-RELATED COSTS						
6	TOTAL	6,943,654	-246,337	6,697,317			
7	NET SALARIES						
8	EXCLUDED AREA SALARIES						
9	SUBTOTAL SALARIES						
10	SUBTOTAL OTHER WAGES & RELATED COSTS						
11	SUBTOTAL WAGE-RELATED COSTS						
12	TOTAL						
13	TOTAL OVERHEAD COSTS	3,277,651	-927,444	2,350,207			

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
I 14-1348	I FROM 7/ 1/2007	I WORKSHEET S-4
I HHA NO:	I TO 6/30/2008	I
I 14-7486	I	I
I COUNTY:	RANDOLPH	

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	156	0	50
2 UNDUPLICATED CENSUS COUNT		361.00		41.00

TOTAL
5

1 HOME HEALTH AIDE HOURS	206
2 UNDUPLICATED CENSUS COUNT	402.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

HHA NO. OF FTE EMPLOYEES (2080 HRS)

	STAFF 1	CONTRACT 2	TOTAL 3
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.05		1.05
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5 OTHER ADMINISTRATIVE PERSONEL	2.28		2.28
6 DIRECTING NURSING SERVICE	5.14		5.14
7 NURSING SUPERVISOR			
8 PHYSICAL THERAPY SERVICE	3.87		3.87
9 PHYSICAL THERAPY SUPERVISOR			
10 OCCUPATIONAL THERAPY SERVICE	.48		.48
11 OCCUPATIONAL THERAPY SUPERVISOR			
12 SPEECH PATHOLOGY SERVICE		.10	.10
13 SPEECH PATHOLOGY SUPERVISOR			
14 MEDICAL SOCIAL SERVICE			
15 MEDICAL SOCIAL SERVICE SUPERVISOR			
16 HOME HEALTH AIDE	.38		.38
17 HOME HEALTH AIDE SUPERVISOR			
18			
HOME HEALTH AGENCY MSA CODES	1	1.01	
19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	0	2	
20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).		41180	
20.01		99914	

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

	FULL EPISODES WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4
21 SKILLED NURSING VISITS	3,333	0	62	13
22 SKILLED NURSING VISIT CHARGES	500,580	0	9,320	1,950
23 PHYSICAL THERAPY VISITS	3,295	0	12	5
24 PHYSICAL THERAPY VISIT CHARGES	487,660	0	1,776	740
25 OCCUPATIONAL THERAPY VISITS	566	0	0	1
26 OCCUPATIONAL THERAPY VISIT CHARGES	83,768	0	0	148
27 SPEECH PATHOLOGY VISITS	150	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	25,500	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31 HOME HEALTH AIDE VISITS	106	0	2	0
32 HOME HEALTH AIDE VISIT CHARGES	10,596	0	198	0
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	7,450	0	76	19
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	1,108,104	0	11,294	2,838
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	447	0	30	2
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	24,619	0	1,216	569

Health Financial Systems MCRIF32

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 S-4 (05/2008)

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/25/2008
I	14-1348	I	FROM 7/ 1/2007	I	WORKSHEET S-4
I	HHA NO:	I	TO 6/30/2008	I	
I	14-7486	I		I	
	COUNTY:		RANDOLPH		

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	25	3,433
22 SKILLED NURSING VISIT CHARGES	0	3,750	515,600
23 PHYSICAL THERAPY VISITS	0	43	3,355
24 PHYSICAL THERAPY VISIT CHARGES	0	6,364	496,540
25 OCCUPATIONAL THERAPY VISITS	0	7	574
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	1,036	84,952
27 SPEECH PATHOLOGY VISITS	0	0	150
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	25,500
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	108
32 HOME HEALTH AIDE VISIT CHARGES	0	0	10,794
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	75	7,620
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	11,150	1,133,386
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	4	483
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	475	26,879

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 14-1348
II PERIOD:
I FROM 7/ 1/2007
I TO 6/30/2008I PREPARED 11/25/2008
I WORKSHEET A
I

	COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
		GENERAL SERVICE COST CNTR					
1	0100	OLD CAP REL COSTS-BLDG & FIXT					
2	0200	OLD CAP REL COSTS-MVBLE EQUIP					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		118,364	118,364	81,899	200,263
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		431,640	431,640	236,360	668,000
5	0500	EMPLOYEE BENEFITS	106,215	94,861	201,076	880,443	1,081,519
6	0600	ADMINISTRATIVE & GENERAL	1,822,034	6,137,336	7,959,370	-2,127,894	5,831,476
8	0800	OPERATION OF PLANT	170,254	1,029,952	1,200,206	-60,494	1,139,712
9	0900	LAUNDRY & LINEN SERVICE	201	34,967	35,168		35,168
10	1000	HOUSEKEEPING	154,519	39,580	194,099	-14,103	179,996
11	1100	DIETARY	151	903,373	903,524	-215	903,309
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	594,891	95,986	690,877	-46,846	644,031
15	1500	CENTRAL SERVICES & SUPPLY	32,538	226,895	259,433	-172,122	87,311
16	1600	PHARMACY	207,491	418,241	625,732	-403,408	222,324
17	1700	MEDICAL RECORDS & LIBRARY	189,357	136,910	326,267	-17,404	308,863
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	855,442	467,080	1,322,522	-9,527	1,312,995
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	361,487	148,465	509,952	-32,722	477,230
40	4000	ANESTHESIOLOGY	340,546	65,722	406,268	-3,356	402,912
41	4100	RADIOLOGY-DIAGNOSTIC	483,584	760,747	1,244,331	-110,911	1,133,420
44	4400	LABORATORY	386,672	624,738	1,011,410	-5,970	1,005,440
49	4900	RESPIRATORY THERAPY	96,091	48,995	145,086	-27,407	117,679
50	5000	PHYSICAL THERAPY	290,070	27,358	317,428	-161	317,267
51	5100	OCCUPATIONAL THERAPY	57,522	16,503	74,025		74,025
52	5200	SPEECH PATHOLOGY		35,440	35,440		35,440
53	5300	ELECTROCARDIOLOGY	65,118	52,471	117,589		117,589
54.10	3950	CARDIAC REHAB	3,083	399	3,482		3,482
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS				199,516	199,516
56	5600	DRUGS CHARGED TO PATIENTS				379,240	379,240
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	726,388	174,142	900,530	927,631	1,828,161
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63.50	6310	RHC					
		OTHER REIMBURS COST CNTRS					
71	7100	HOME HEALTH AGENCY	627,754	213,116	840,870	-22,223	818,647
		SPEC PURPOSE COST CENTERS					
95		SUBTOTALS	7,571,408	12,303,281	19,874,689	-349,674	19,525,015
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	22,205	62,046	84,251	-41	84,210
100	7950	SENIOR CIRCLE	3,720	1,058	4,778		4,778
100.01	7951	FREE STANDING NURSING HOME				269,291	269,291
100.02	7952	OTHER NONREIMBURSABLE COST CENTER				80,424	80,424
101		TOTAL	7,597,333	12,366,385	19,963,718	-0-	19,963,718

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:

I PERIOD:

I PREPARED 11/25/2008

I 14-1348

I FROM 7/ 1/2007

I WORKSHEET A

I

I TO 6/30/2008

I

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
		GENERAL SERVICE COST CNTR		
1	0100	OLD CAP REL COSTS-BLDG & FIXT		
2	0200	OLD CAP REL COSTS-MVBLE EQUIP		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	260,991	461,254
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	131,117	799,117
5	0500	EMPLOYEE BENEFITS	-1,004	1,080,515
6	0600	ADMINISTRATIVE & GENERAL	-3,026,685	2,804,791
8	0800	OPERATION OF PLANT		1,139,712
9	0900	LAUNDRY & LINEN SERVICE	41,772	76,940
10	1000	HOUSEKEEPING		179,996
11	1100	DIETARY	291,402	1,194,711
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION	-400	643,631
15	1500	CENTRAL SERVICES & SUPPLY		87,311
16	1600	PHARMACY		222,324
17	1700	MEDICAL RECORDS & LIBRARY	-333	308,530
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,312,995
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		477,230
40	4000	ANESTHESIOLOGY	-382,813	20,099
41	4100	RADIOLOGY-DIAGNOSTIC		1,133,420
44	4400	LABORATORY	-82,571	922,869
49	4900	RESPIRATORY THERAPY		117,679
50	5000	PHYSICAL THERAPY		317,267
51	5100	OCCUPATIONAL THERAPY		74,025
52	5200	SPEECH PATHOLOGY		35,440
53	5300	ELECTROCARDIOLOGY	-15,769	101,820
54.10	3950	CARDIAC REHAB		3,482
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		199,516
56	5600	DRUGS CHARGED TO PATIENTS	-3,495	375,745
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-430,347	1,397,814
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63.50	6310	RHC		
		OTHER REIMBURS COST CNTRS		
71	7100	HOME HEALTH AGENCY	47,398	866,045
		SPEC PURPOSE COST CENTERS		
95		SUBTOTALS	-3,170,737	16,354,278
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		84,210
100	7950	SENIOR CIRCLE		4,778
100.01	7951	FREE STANDING NURSING HOME		269,291
100.02	7952	OTHER NONREIMBURSABLE COST CENTER		80,424
101		TOTAL	-3,170,737	16,792,981

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
25	INPAT ROUTINE SRVC C		
	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54.10	CARDIAC REHAB	3950	OTHER ANCILLARY SERVICE COST CENTERS
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63.50	RHC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	SENIOR CIRCLE	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	FREE STANDING NURSING HOME	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	OTHER NONREIMBURSABLE COST CENTER	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

 PROVIDER NO:
 141348

 PERIOD:
 FROM 7/ 1/2007
 TO 6/30/2008

 PREPARED 11/25/2008
 WORKSHEET A-6

		----- INCREASE -----				
EXPLANATION OF RECLASSIFICATION		CODE (1)	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 RECLASS EMPLOYEE BENEFITS		A	EMPLOYEE BENEFITS	5		941,050
2			ADULTS & PEDIATRICS	25		430
3 RECLASS OXYGEN COSTS		B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		13,349
4						
5						
6 RECLASS RENTS & LEASES		C	NEW CAP REL COSTS-BLDG & FIXT	3		18,000
7			NEW CAP REL COSTS-MVBLE EQUIP	4		231,388
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25 RECLASS OTHER CAPITAL		D	NEW CAP REL COSTS-BLDG & FIXT	3		63,899
26			NEW CAP REL COSTS-MVBLE EQUIP	4		4,972
27 RECLASS MARKETING COSTS		E	OTHER NONREIMBURSABLE COST CENTER	100.02	34,614	45,810
28 RECLASS CHARGEABLE MEDICAL SUPP		F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		159,651
29			MEDICAL SUPPLIES CHARGED TO PATIENTS	55		26,516
30 RECLASS CHARGEABLE DRUGS		G	DRUGS CHARGED TO PATIENTS	56		379,240
31 RECLASS ER PHYSICIAN COSTS		H	EMERGENCY	61	681,107	299,407
32 RECLASS NURSING HOME SVCS		I	FREE STANDING NURSING HOME	100.01	211,723	57,568
33						
34						
35						
1 RECLASS NURSING HOME SVCS		I				
2						
36 TOTAL RECLASSIFICATIONS					927,444	2,241,280

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

 PROVIDER NO:
141348

 PERIOD:
FROM 7/ 1/2007
TO 6/30/2008

 PREPARED 11/25/2008
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 RECLASS EMPLOYEE BENEFITS	A	ADMINISTRATIVE & GENERAL	6			897,648	
2		EMERGENCY	61			43,832	
3 RECLASS OXYGEN COSTS	B	OPERATING ROOM	37			648	
4		ANESTHESIOLOGY	40			3,148	
5		RESPIRATORY THERAPY	49			9,553	
6 RECLASS RENTS & LEASES	C	EMPLOYEE BENEFITS	5			84	10
7		ADMINISTRATIVE & GENERAL	6			21,635	10
8		OPERATION OF PLANT	8			729	
9		DIETARY	11			215	
10		NURSING ADMINISTRATION	14			182	
11		CENTRAL SERVICES & SUPPLY	15			12,471	
12		PHARMACY	16			24,168	
13		MEDICAL RECORDS & LIBRARY	17			7,835	
14		ADULTS & PEDIATRICS	25			9,957	
15		OPERATING ROOM	37			5,558	
16		RADIOLOGY-DIAGNOSTIC	41			110,911	
17		LABORATORY	44			5,970	
18		RESPIRATORY THERAPY	49			17,854	
19		PHYSICAL THERAPY	50			161	
20		HOUSEKEEPING	10			135	
21		EMERGENCY	61			9,051	
22		HOME HEALTH AGENCY	71			22,223	
23		PHYSICIANS' PRIVATE OFFICES	98			41	
24		ANESTHESIOLOGY	40			208	
25 RECLASS OTHER CAPITAL	D	ADMINISTRATIVE & GENERAL	6			63,899	14
26		ADMINISTRATIVE & GENERAL	6			4,972	14
27 RECLASS MARKETING COSTS	E	ADMINISTRATIVE & GENERAL	6		34,614	45,810	
28 RECLASS CHARGEABLE MEDICAL SUPP	F	CENTRAL SERVICES & SUPPLY	15			159,651	
29		OPERATING ROOM	37			26,516	
30 RECLASS CHARGEABLE DRUGS	G	PHARMACY	16			379,240	
31 RECLASS ER PHYSICIAN COSTS	H	ADMINISTRATIVE & GENERAL	6		681,107	299,407	
32 RECLASS NURSING HOME SVCS	I	EMPLOYEE BENEFITS	5		32,735	27,788	
33		ADMINISTRATIVE & GENERAL	6		72,435	6,367	
34		OPERATION OF PLANT	8		38,001	21,764	
35		HOUSEKEEPING	10		13,968		
1 RECLASS NURSING HOME SVCS	I	NURSING ADMINISTRATION	14		45,015	1,649	
2		MEDICAL RECORDS & LIBRARY	17		9,569		
36 TOTAL RECLASSIFICATIONS					927,444	2,241,280	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:
141348PERIOD:
FROM 7/ 1/2007
TO 6/30/2008PREPARED 11/25/2008
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: A

EXPLANATION : RECLASS EMPLOYEE BENEFITS

LINE	COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	941,050
2.00	ADULTS & PEDIATRICS	25	430
TOTAL RECLASSIFICATIONS FOR CODE A			941,480

COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	897,648
EMERGENCY	61	43,832
		941,480

RECLASS CODE: B

EXPLANATION : RECLASS OXYGEN COSTS

LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	13,349
2.00			0
3.00			0
TOTAL RECLASSIFICATIONS FOR CODE B			13,349

COST CENTER	LINE	AMOUNT
OPERATING ROOM	37	648
ANESTHESIOLOGY	40	3,148
RESPIRATORY THERAPY	49	9,553
		13,349

RECLASS CODE: C

EXPLANATION : RECLASS RENTS & LEASES

LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	18,000
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	231,388
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
13.00			0
14.00			0
15.00			0
16.00			0
17.00			0
18.00			0
19.00			0
TOTAL RECLASSIFICATIONS FOR CODE C			249,388

COST CENTER	LINE	AMOUNT
EMPLOYEE BENEFITS	5	84
ADMINISTRATIVE & GENERAL	6	21,635
OPERATION OF PLANT	8	729
DIETARY	11	215
NURSING ADMINISTRATION	14	182
CENTRAL SERVICES & SUPPLY	15	12,471
PHARMACY	16	24,168
MEDICAL RECORDS & LIBRARY	17	7,835
ADULTS & PEDIATRICS	25	9,957
OPERATING ROOM	37	5,558
RADIOLOGY-DIAGNOSTIC	41	110,911
LABORATORY	44	5,970
RESPIRATORY THERAPY	49	17,854
PHYSICAL THERAPY	50	161
HOUSEKEEPING	10	135
EMERGENCY	61	9,051
HOME HEALTH AGENCY	71	22,223
PHYSICIANS' PRIVATE OFFICES	98	41
ANESTHESIOLOGY	40	208
		249,388

RECLASS CODE: D

EXPLANATION : RECLASS OTHER CAPITAL

LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	63,899
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	4,972
TOTAL RECLASSIFICATIONS FOR CODE D			68,871

COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	63,899
ADMINISTRATIVE & GENERAL	6	4,972
		68,871

RECLASS CODE: E

EXPLANATION : RECLASS MARKETING COSTS

LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER NONREIMBURSABLE COST CEN	100.02	80,424
TOTAL RECLASSIFICATIONS FOR CODE E			80,424

COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	80,424
		80,424

RECLASS CODE: F

EXPLANATION : RECLASS CHARGEABLE MEDICAL SUPP

LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	159,651
2.00	MEDICAL SUPPLIES CHARGED TO PA	55	26,516
TOTAL RECLASSIFICATIONS FOR CODE F			186,167

COST CENTER	LINE	AMOUNT
CENTRAL SERVICES & SUPPLY	15	159,651
OPERATING ROOM	37	26,516
		186,167

RECLASS CODE: G

EXPLANATION : RECLASS CHARGEABLE DRUGS

LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	379,240
TOTAL RECLASSIFICATIONS FOR CODE G			379,240

COST CENTER	LINE	AMOUNT
PHARMACY	16	379,240
		379,240

RECLASSIFICATIONS

PROVIDER NO:
141348

PERIOD:

FROM 7/ 1/2007

TO 6/30/2008

PREPARED 11/25/2008

WORKSHEET A-6

NOT A CMS WORKSHEET

RECLASS CODE: H

EXPLANATION : RECLASS ER PHYSICIAN COSTS

----- INCREASE -----		LINE	AMOUNT
LINE	COST CENTER		
1.00	EMERGENCY	61	980,514
TOTAL RECLASSIFICATIONS FOR CODE H			980,514

----- DECREASE -----		LINE	AMOUNT
COST CENTER			
ADMINISTRATIVE & GENERAL		6	980,514
			980,514

RECLASS CODE: I

EXPLANATION : RECLASS NURSING HOME SVCS

----- INCREASE -----		LINE	AMOUNT
LINE	COST CENTER		
1.00	FREE STANDING NURSING HOME	100.01	269,291
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
TOTAL RECLASSIFICATIONS FOR CODE I			269,291

----- DECREASE -----		LINE	AMOUNT
COST CENTER			
EMPLOYEE BENEFITS		5	60,523
ADMINISTRATIVE & GENERAL		6	78,802
OPERATION OF PLANT		8	59,765
HOUSEKEEPING		10	13,968
NURSING ADMINISTRATION		14	46,664
MEDICAL RECORDS & LIBRARY		17	9,569
			269,291

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE		2,350				2,350	
4	BUILDING IMPROVEMEN	5,154,179	292,462		292,462		5,446,641	
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	10,064,651	246,709		246,709		10,311,360	
7	SUBTOTAL	15,221,180	539,171		539,171		15,760,351	
8	RECONCILING ITEMS							
9	TOTAL	15,221,180	539,171		539,171		15,760,351	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL					
		GROSS ASSETS	CAPITIALIZED GROSS ASSETS	FOR RATIO		INSURANCE	TAXES	OTHER CAPITAL	TOTAL	
*		1	LEASES	2	3	4	5	6	7	8
1	OLD CAP REL COSTS-BL									
2	OLD CAP REL COSTS-MV									
3	NEW CAP REL COSTS-BL	5,448,991			5,448,991	.345740				
4	NEW CAP REL COSTS-MV	10,311,360			10,311,360	.654260				
5	TOTAL	15,760,351			15,760,351	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	359,148	18,000				84,106	461,254
4	NEW CAP REL COSTS-MV	543,303	231,388				24,426	799,117
5	TOTAL	902,451	249,388				108,532	1,260,371

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4
DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	118,364						118,364
4	NEW CAP REL COSTS-MV	431,640						431,640
5	TOTAL	550,004						550,004

- * All lines numbers except line 5 are to be consistent with workshseet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

I PROVIDER NO:

I PERIOD:

I PREPARED 11/25/2008

I 14-1348

I FROM 7/ 1/2007

I WORKSHEET A-8

I

I TO 6/30/2008

I

DESCRIPTION (1)		(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-3,346	ADMINISTRATIVE & GENERAL	6	
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-15,245	ADMINISTRATIVE & GENERAL	6	
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-531,173			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-1,432,546			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-94,584	DIETARY	11	
17	RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-3,495	DRUGS CHARGED TO PATIENTS	56	
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-333	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-35	ADMINISTRATIVE & GENERAL	6	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES	A	142,446	NEW CAP REL COSTS-BLDG &	3	9
32	DEPRECIATION-NEW MOVABLE EQUIP	A	112,334	NEW CAP REL COSTS-MVBLE E	4	9
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37	FEES FROM INSERVICE EDUCATION	B	-400	NURSING ADMINISTRATION	14	
38	OTHER MISC REVENUE	B	-5,348	ADMINISTRATIVE & GENERAL	6	
39	HOSPITAL BAD DEBTS	A	-987,497	ADMINISTRATIVE & GENERAL	6	
40	HHA BAD DEBTS	A	39,740	HOME HEALTH AGENCY	71	
41	NONALLOWABLE DUES	A	-1,440	ADMINISTRATIVE & GENERAL	6	
42	OFFSET HHA INTEREST INCOME	A	-12	HOME HEALTH AGENCY	71	
43	NONALLOWABLE DUES AND FEES	A	-1,133	ADMINISTRATIVE & GENERAL	6	
44	CHARITABLE CONTRIBUTIONS	A	-270	ADMINISTRATIVE & GENERAL	6	
45	OFFSET HRSA GRANT	B	-15,395	ADMINISTRATIVE & GENERAL	6	
45.01	OFFSET PHONE FRINGES	A	-1,004	EMPLOYEE BENEFITS	5	
45.02	OFFSET PHONE DEPR	A	-171	NEW CAP REL COSTS-MVBLE E	4	9
45.03	OFFSET CLUB DUES	A	-35	ADMINISTRATIVE & GENERAL	6	
45.04	OFFSET ADDITIONAL LOBBYING EXPE	A	-10,766	ADMINISTRATIVE & GENERAL	6	
45.05	OFFSET GAIN ON SALE OF ASSETS	B	-500	NEW CAP REL COSTS-MVBLE E	4	9
46	ADD BACK NH CREDIT FOR DIETARY	A	385,986	DIETARY	11	
47	NONALLOWABLE PHYSICIAN COSTS	A	-12,000	ADMINISTRATIVE & GENERAL	6	
48	OFFSET CRNA COSTS	A	-382,813	ANESTHESIOLOGY	40	
49	PROVIDER TAX	A	-359,304	ADMINISTRATIVE & GENERAL	6	
49.01	OFFSET SBC SATELLITE DISH REV	B	-2,400	ADMINISTRATIVE & GENERAL	6	
49.02	LATE FEES AND PENALTIES	A	-788	ADMINISTRATIVE & GENERAL	6	
49.03	ADD BACK NURSING HOME LAUNDRY C	A	41,772	LAUNDRY & LINEN SERVICE	9	
49.04	LEGAL FEES	A	-30,982	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-3,170,737			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG & DIRECT ALLOCATION	98,338		98,338	9
2	3	NEW CAP REL COSTS-BLDG & PASI CAPITAL COSTS	15,439		15,439	14
3	6	ADMINISTRATIVE & GENERAL PASI OPERATING COSTS	171,348		171,348	
4	71	HOME HEALTH AGENCY HOME HEALTH FUNCTIONAL	7,670		7,670	
4.01	3	NEW CAP REL COSTS-BLDG & POOLED HO COSTS	4,768		4,768	14
4.02	4	NEW CAP REL COSTS-MVBLE E POOLED HO COSTS	19,454		19,454	14
4.03	6	ADMINISTRATIVE & GENERAL POOLED HO COSTS	316,304		316,304	14
4.04	6	ADMINISTRATIVE & GENERAL MALPRACTICE COSTS	389,261	2,455,128	-2,065,867	14
5		TOTALS	1,022,582	2,455,128	-1,432,546	

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B	0.00	COMMUNITY HEALTH SYSTEMS	100.00	HOSPITAL MGMT COMPANY
2		0.00		0.00	
3		0.00		0.00	
4		0.00		0.00	
5		0.00		0.00	

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
 - DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 14-1348
II PERIOD:
I FROM 7/ 1/2007 I PREPARED 11/25/2008
I TO 6/30/2008 I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 6	ADMINISTRATIVE & GENERAL	2,486	2,486					
2 44	DIRECTORSHIP	82,571	82,571					
3 53	ELECTROCARDIOLOGY	15,769	15,769					
4 61	EMERGENCY	980,513	430,347	550,166				
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,081,339	531,173	550,166				

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	9
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	135
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	26
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	244.99			
10	AHSEA (SEE INSTRUCTIONS)	62.29			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	31.15	31.15		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	15,260
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	15,260
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	15,260

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	15,260

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	91
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	91
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 91

34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)

35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)

37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)

38 SUBTOTAL (SUM OF LINES 36 AND 37)

39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)

40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)

41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)

42 SUBTOTAL (SUM OF LINES 40 AND 41)

43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)

45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)

46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)	1	2	3	4	5
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 15,260

58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 91

59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)

60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

61 EQUIPMENT COST (SEE INSTRUCTIONS)

62 SUPPLIES (SEE INSTRUCTIONS)

63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 15,351

64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 12,679

Health Financial Systems	MCRIF32	FOR RED BUD REGIONAL HOSPITAL	IN LIEU OF FORM CMS-2552-96(12/1999)
REASONABLE COST DETERMINATION FOR THERAPY		I PROVIDER NO: I 14-1348	I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/25/2008 I WORKSHEET A-8-4 I PARTS I - VII
SERVICES FURNISHED BY OUTSIDE SUPPLIERS			
ON OR AFTER APRIL 10, 1998			
OCCUPATIONAL THERAPY			

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF
NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES
66 COST OF OUTSIDE SUPPLIER SERVICES - 12,679
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS
LINE MUST AGREE WITH LINE 64) 12,679

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000

68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)

68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)

69 EXCESS COST OVER LIMITATION-
(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

69.01 EXCESS COST OVER LIMITATION-CORF I
(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

69.31 EXCESS COST OVER LIMITATION- HHA I
(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE
WITH LINE 65)

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	50
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	750
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	351
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		835.75		
10	AHSEA (SEE INSTRUCTIONS)		59.86		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	29.93	29.93		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	50,028
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	50,028
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	50,028

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	50,028

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	10,505
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	10,505
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,229
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	11,734

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

SPEECH PATHOLOGY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 11,734

34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)

35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE
STANDARD TRAVEL EXPENSE

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)

37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)

38 SUBTOTAL (SUM OF LINES 36 AND 37)

39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)

40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)

41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)

42 SUBTOTAL (SUM OF LINES 40 AND 41)

43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)

45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)

46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)	1	2	3	4	5
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 50,028

58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 11,734

59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)

60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

61 EQUIPMENT COST (SEE INSTRUCTIONS)

62 SUPPLIES (SEE INSTRUCTIONS)

63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 61,762

64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 47,036

Health Financial Systems	MCRIF32	FOR RED BUD REGIONAL HOSPITAL	IN LIEU OF FORM CMS-2552-96(12/1999)
REASONABLE COST DETERMINATION FOR THERAPY		I PROVIDER NO: I 14-1348	I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008
SERVICES FURNISHED BY OUTSIDE SUPPLIERS			I PREPARED 11/25/2008 I WORKSHEET A-8-4 I PARTS I - VII
ON OR AFTER APRIL 10, 1998			

SPEECH PATHOLOGY

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF
NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES -	32,753
	(SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I	
	(SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	14,283
	(SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	47,036
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	.696339
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	.303661
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
 I 14-1348 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET
 I I TO 6/30/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	NOT ENTERED
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	4	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	6	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	7	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	8	SQUARE FEET	ENTERED
11	DIETARY	9	MEALS SERVED	ENTERED
12	CAFETERIA	10	MEALS SERVED	ENTERED
14	NURSING ADMINISTRATION	11	NURSING SALARIES	ENTERED
15	CENTRAL SERVICES & SUPPLY	12	COSTED REQUIS.	ENTERED
16	PHARMACY	13	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	14	GROSS REVENUE	ENTERED

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL
	0	1	2	3	4	5	5a.00
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &	461,254			461,254			
005 NEW CAP REL COSTS-MVBLE E	799,117				799,117		
006 EMPLOYEE BENEFITS	1,080,515			3,886	6,733	1,091,134	
008 ADMINISTRATIVE & GENERAL	2,804,791			73,259	126,920	157,045	3,162,015
009 OPERATION OF PLANT	1,139,712			113,482	196,608	20,089	1,469,891
010 LAUNDRY & LINEN SERVICE	76,940			810	1,403	31	79,184
011 HOUSEKEEPING	179,996			6,684	11,579	21,350	219,609
012 DIETARY	1,194,711			20,965	36,321	23	1,252,020
014 CAFETERIA				10,336	17,906		28,242
015 NURSING ADMINISTRATION	643,631			11,242	19,477	83,526	757,876
016 CENTRAL SERVICES & SUPPLY	87,311					4,942	92,253
017 PHARMACY	222,324					31,518	253,842
025 MEDICAL RECORDS & LIBRARY	308,530			10,859	18,814	27,310	365,513
037 INPAT ROUTINE SRVC CNTRS							
040 ADULTS & PEDIATRICS	1,312,995			40,369	69,938	129,941	1,553,243
044 ANCILLARY SRVC COST CNTRS							
049 OPERATING ROOM	477,230			26,556	46,008	54,910	604,704
051 ANESTHESIOLOGY	20,099			776	1,345		22,220
053 RADIOLOGY-DIAGNOSTIC	1,133,420			21,303	36,907	73,456	1,265,086
055 LABORATORY	922,869			10,417	18,048	58,735	1,010,069
056 RESPIRATORY THERAPY	117,679			2,731	4,731	14,596	139,737
061 PHYSICAL THERAPY	317,267			11,706	20,281	44,061	393,315
062 OCCUPATIONAL THERAPY	74,025			1,843	3,192	8,738	87,798
063 SPEECH PATHOLOGY	35,440			750	1,300		37,490
066 ELECTROCARDIOLOGY	101,820			3,667	6,353	9,891	121,731
071 10 CARDIAC REHAB	3,482			654	1,133	468	5,737
075 MEDICAL SUPPLIES CHARGED	199,516			3,117	5,400		208,033
080 DRUGS CHARGED TO PATIENTS	375,745			5,257	9,108		390,110
085 OUTPAT SERVICE COST CNTRS							
090 EMERGENCY	1,397,814			10,547	18,273	213,792	1,640,426
095 OBSERVATION BEDS (NON-DIS							
100 50 RHC							
105 OTHER REIMBURS COST CNTRS							
110 HOME HEALTH AGENCY	866,045			11,487	19,901	95,355	992,788
115 SPEC PURPOSE COST CENTERS							
120 SUBTOTALS	16,354,278			402,703	697,679	1,049,777	16,152,932
125 NONREIMBURS COST CENTERS							
130 GIFT, FLOWER, COFFEE SHOP				1,984	3,437		5,421
135 PHYSICIANS' PRIVATE OFFIC	84,210			52,499	90,953	3,373	231,035
140 SENIOR CIRCLE	4,778			1,939	3,360	565	10,642
145 01 FREE STANDING NURSING HOM	269,291					32,161	301,452
150 02 OTHER NONREIMBURSABLE COS	80,424			2,129	3,688	5,258	91,499
155 CROSS FOOT ADJUSTMENT							
160 NEGATIVE COST CENTER							
165 TOTAL	16,792,981			461,254	799,117	1,091,134	16,792,981

COST CENTER DESCRIPTION	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
	6	8	9	10	11	12	14
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	3,162,015						
009 OPERATION OF PLANT	348,686	1,818,577					
010 LAUNDRY & LINEN SERVICE	18,784	5,816	103,784				
011 HOUSEKEEPING	52,095	47,996		319,700			
012 DIETARY	297,003	150,552		25,471	1,725,046		
014 CAFETERIA	6,700	74,222		12,557	301,842	423,563	
015 NURSING ADMINISTRATION	179,783	80,732		13,659		34,089	1,066,139
016 CENTRAL SERVICES & SUPPLY	21,884					6,067	
017 PHARMACY	60,216					9,341	
025 MEDICAL RECORDS & LIBRARY	86,707	77,984		13,194		24,589	
037 INPAT ROUTINE SRVC CNTRS							
040 ADULTS & PEDIATRICS	368,459	289,899	103,784	49,047	203,640	105,382	313,445
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	143,447	190,705		32,265		30,058	132,454
049 ANESTHESIOLOGY	5,271	5,576		943			
050 RADIOLOGY-DIAGNOSTIC	300,102	152,980		25,882		41,195	177,191
051 LABORATORY	239,608	74,809		12,657		37,003	141,682
052 RESPIRATORY THERAPY	33,148	19,609		3,318		2,874	35,209
053 PHYSICAL THERAPY	93,302	84,067		14,223		20,358	
054 OCCUPATIONAL THERAPY	20,827	13,233		2,239		3,952	
055 SPEECH PATHOLOGY	8,893	5,389		912			
056 ELECTROCARDIOLOGY	28,877	26,333		4,455		1,876	
10 CARDIAC REHAB	1,361	4,696		794		240	
061 MEDICAL SUPPLIES CHARGED	49,349	22,384		3,787			
062 DRUGS CHARGED TO PATIENTS	92,542	37,751		6,387			
063 OUTPAT SERVICE COST CNTRS							
071 EMERGENCY	389,142	75,743		12,815		71,811	266,158
095 OBSERVATION BEDS (NON-DIS							
096 50 RHC							
097 OTHER REIMBURS COST CNTRS							
098 HOME HEALTH AGENCY	235,508	82,493		13,957		15,967	
099 SPEC PURPOSE COST CENTERS							
100 SUBTOTALS	3,081,694	1,522,969	103,784	248,562	505,482	404,802	1,066,139
101 NONREIMBURS COST CENTERS							
102 GIFT, FLOWER, COFFEE SHOP	1,286	14,247		2,410			
103 PHYSICIANS' PRIVATE OFFIC	54,806	252,147		63,786			
100 SENIOR CIRCLE	2,524	13,927		2,356			
101 01 FREE STANDING NURSING HOM					1,219,564	15,129	
102 02 OTHER NONREIMBURSABLE COS	21,705	15,287		2,586		3,632	
103 CROSS FOOT ADJUSTMENT							
104 NEGATIVE COST CENTER							
105 TOTAL	3,162,015	1,818,577	103,784	319,700	1,725,046	423,563	1,066,139

COST CENTER DESCRIPTION		CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SUBTOTAL	I&R COST POST STEP- DOWN ADJ 26	TOTAL
		15	16	17	25	26	27
001	GENERAL SERVICE COST CNTR						
002	OLD CAP REL COSTS-BLDG &						
003	OLD CAP REL COSTS-MVBLE E						
004	NEW CAP REL COSTS-BLDG &						
005	NEW CAP REL COSTS-MVBLE E						
006	EMPLOYEE BENEFITS						
008	ADMINISTRATIVE & GENERAL						
009	OPERATION OF PLANT						
010	LAUNDRY & LINEN SERVICE						
011	HOUSEKEEPING						
012	DIETARY						
014	CAFETERIA						
015	NURSING ADMINISTRATION						
016	CENTRAL SERVICES & SUPPLY	120,204					
017	PHARMACY	1,073	324,472				
025	MEDICAL RECORDS & LIBRARY	608		568,595			
025	INPAT ROUTINE SRVC CNTRS						
037	ADULTS & PEDIATRICS	16,522		44,908	3,048,329		3,048,329
040	ANCILLARY SRVC COST CNTRS						
041	OPERATING ROOM	18,093		56,379	1,208,105		1,208,105
044	ANESTHESIOLOGY	1,934		2,806	38,750		38,750
049	RADIOLOGY-DIAGNOSTIC	6,945		183,614	2,152,995		2,152,995
050	LABORATORY	9,561		109,474	1,634,863		1,634,863
051	RESPIRATORY THERAPY	852		3,856	238,603		238,603
052	PHYSICAL THERAPY	700		18,704	624,669		624,669
053	OCCUPATIONAL THERAPY	107		4,133	132,289		132,289
054	SPEECH PATHOLOGY			800	53,484		53,484
055	ELECTROCARDIOLOGY	25		23,627	206,924		206,924
056	10 CARDIAC REHAB	29		1,393	14,250		14,250
061	MEDICAL SUPPLIES CHARGED	51,288		34,311	369,152		369,152
062	DRUGS CHARGED TO PATIENTS		324,472	26,451	877,713		877,713
063	OUTPAT SERVICE COST CNTRS						
071	EMERGENCY	10,248		40,540	2,506,883		2,506,883
095	50 OBSERVATION BEDS (NON-DIS						
096	OTHER REIMBURS COST CNTRS						
098	HOME HEALTH AGENCY	2,098		17,599	1,360,410		1,360,410
100	SPEC PURPOSE COST CENTERS						
101	01 FREE STANDING NURSING HOM						
102	02 OTHER NONREIMBURSABLE COS						
103	CROSS FOOT ADJUSTMENT						
104	NEGATIVE COST CENTER						
105	TOTAL	120,204	324,472	568,595	16,792,981		16,792,981

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION		DIR ASSIGNED NEW CAPITAL REL COSTS 0	OLD CAP REL C OSTS-BLDG & 1	OLD CAP REL C OSTS-MVBLE E 2	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5
001	GENERAL SERVICE COST CNTR							
002	OLD CAP REL COSTS-BLDG &							
003	OLD CAP REL COSTS-MVBLE E							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS				3,886	6,733	10,619	10,619
008	ADMINISTRATIVE & GENERAL				73,259	126,920	200,179	1,528
009	OPERATION OF PLANT				113,482	196,608	310,090	195
010	LAUNDRY & LINEN SERVICE				810	1,403	2,213	
011	HOUSEKEEPING				6,684	11,579	18,263	208
012	DIETARY				20,965	36,321	57,286	
014	CAFETERIA				10,336	17,906	28,242	
015	NURSING ADMINISTRATION				11,242	19,477	30,719	813
016	CENTRAL SERVICES & SUPPLY							48
017	PHARMACY							307
025	MEDICAL RECORDS & LIBRARY				10,859	18,814	29,673	266
037	INPAT ROUTINE SRVC CNTRS							
040	ADULTS & PEDIATRICS				40,369	69,938	110,307	1,264
041	ANCILLARY SRVC COST CNTRS							
044	OPERATING ROOM				26,556	46,008	72,564	534
049	ANESTHESIOLOGY				776	1,345	2,121	
050	RADIOLOGY-DIAGNOSTIC				21,303	36,907	58,210	715
051	LABORATORY				10,417	18,048	28,465	572
052	RESPIRATORY THERAPY				2,731	4,731	7,462	142
053	PHYSICAL THERAPY				11,706	20,281	31,987	429
054	OCCUPATIONAL THERAPY				1,843	3,192	5,035	85
055	SPEECH PATHOLOGY				750	1,300	2,050	
056	ELECTROCARDIOLOGY				3,667	6,353	10,020	96
061	10 CARDIAC REHAB				654	1,133	1,787	5
062	MEDICAL SUPPLIES CHARGED				3,117	5,400	8,517	
063	DRUGS CHARGED TO PATIENTS				5,257	9,108	14,365	
071	OUTPAT SERVICE COST CNTRS							
095	EMERGENCY				10,547	18,273	28,820	2,082
100	01 OBSERVATION BEDS (NON-DIS							
100	02 RHC							
101	OTHER REIMBURS COST CNTRS							
102	HOME HEALTH AGENCY				11,487	19,901	31,388	928
103	SPEC PURPOSE COST CENTERS							
104	SUBTOTALS				402,703	697,679	1,100,382	10,217
105	NONREIMBURS COST CENTERS							
106	GIFT, FLOWER, COFFEE SHOP				1,984	3,437	5,421	
107	PHYSICIANS' PRIVATE OFFIC				52,499	90,953	143,452	33
108	SENIOR CIRCLE				1,939	3,360	5,299	5
109	01 FREE STANDING NURSING HOM							313
110	02 OTHER NONREIMBURSABLE COS				2,129	3,688	5,817	51
111	CROSS FOOT ADJUSTMENTS							
112	NEGATIVE COST CENTER							
113	TOTAL				461,254	799,117	1,260,371	10,619

I PROVIDER NO:

I PERIOD:

I PREPARED 11/25/2008

ALLOCATION OF NEW CAPITAL RELATED COSTS

I 14-1348

I FROM 7/ 1/2007

I WORKSHEET B

I

I TO 6/30/2008

I PART III

COST CENTER DESCRIPTION		ADMINISTRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14
001	GENERAL SERVICE COST CNTR							
002	OLD CAP REL COSTS-BLDG &							
003	OLD CAP REL COSTS-MVBLE E							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL	201,707						
009	OPERATION OF PLANT	22,242	332,527					
010	LAUNDRY & LINEN SERVICE	1,198	1,063	4,474				
011	HOUSEKEEPING	3,323	8,776		30,570			
012	DIETARY	18,946	27,528		2,436	106,196		
014	CAFETERIA	427	13,572		1,201	18,582	62,024	
015	NURSING ADMINISTRATION	11,468	14,762		1,306		4,992	64,060
016	CENTRAL SERVICES & SUPPLY	1,396					888	
017	PHARMACY	3,841					1,368	
025	MEDICAL RECORDS & LIBRARY	5,531	14,259		1,262		3,601	
037	INPAT ROUTINE SRVC CNTRS							
040	ADULTS & PEDIATRICS	23,504	53,008	4,474	4,690	12,536	15,431	18,834
041	ANCILLARY SRVC COST CNTRS							
044	OPERATING ROOM	9,150	34,870		3,085		4,401	7,958
049	ANESTHESIOLOGY	336	1,020		90			
050	RADIOLOGY-DIAGNOSTIC	19,143	27,972		2,475		6,032	10,647
051	LABORATORY	15,284	13,679		1,210		5,419	8,513
052	RESPIRATORY THERAPY	2,115	3,586		317		421	2,116
053	PHYSICAL THERAPY	5,952	15,372		1,360		2,981	
054	OCCUPATIONAL THERAPY	1,329	2,420		214		579	
055	SPEECH PATHOLOGY	567	985		87			
056	ELECTROCARDIOLOGY	1,842	4,815		426		275	
061	10 CARDIAC REHAB	87	859		76		35	
062	MEDICAL SUPPLIES CHARGED	3,148	4,093		362			
063	DRUGS CHARGED TO PATIENTS	5,903	6,903		611			
071	OUTPAT SERVICE COST CNTRS							
095	EMERGENCY	24,828	13,850		1,225		10,516	15,992
100	OBSERVATION BEDS (NON-DIS							
101	50 RHC							
102	OTHER REIMBURS COST CNTRS							
103	HOME HEALTH AGENCY	15,023	15,084		1,335		2,338	
104	SPEC PURPOSE COST CENTERS							
105	SUBTOTALS	196,583	278,476	4,474	23,768	31,118	59,277	64,060
106	NONREIMBURS COST CENTERS							
107	GIFT, FLOWER, COFFEE SHOP	82	2,605		230			
108	PHYSICIANS' PRIVATE OFFIC	3,496	46,105		6,100			
109	SENIOR CIRCLE	161	2,546		225			
110	01 FREE STANDING NURSING HOM					75,078	2,215	
111	02 OTHER NONREIMBURSABLE COS	1,385	2,795		247		532	
112	CROSS FOOT ADJUSTMENTS							
113	NEGATIVE COST CENTER							
114	TOTAL	201,707	332,527	4,474	30,570	106,196	62,024	64,060

	COST CENTER DESCRIPTION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		15	16	17	25	26	27
001	GENERAL SERVICE COST CNTR						
002	OLD CAP REL COSTS-BLDG &						
003	OLD CAP REL COSTS-MVBLE E						
004	NEW CAP REL COSTS-BLDG &						
005	NEW CAP REL COSTS-MVBLE E						
006	EMPLOYEE BENEFITS						
008	ADMINISTRATIVE & GENERAL						
009	OPERATION OF PLANT						
010	LAUNDRY & LINEN SERVICE						
011	HOUSEKEEPING						
012	DIETARY						
012	CAFETERIA						
014	NURSING ADMINISTRATION						
015	CENTRAL SERVICES & SUPPLY	2,332					
016	PHARMACY	21	5,537				
017	MEDICAL RECORDS & LIBRARY	12		54,604			
025	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	321		4,313	248,682		248,682
	ANCILLARY SRVC COST CNTRS						
037	OPERATING ROOM	351		5,414	138,327		138,327
040	ANESTHESIOLOGY	38		269	3,874		3,874
041	RADIOLOGY-DIAGNOSTIC	135		17,633	142,962		142,962
044	LABORATORY	185		10,514	83,841		83,841
049	RESPIRATORY THERAPY	17		370	16,546		16,546
050	PHYSICAL THERAPY	14		1,796	59,891		59,891
051	OCCUPATIONAL THERAPY	2		397	10,061		10,061
052	SPEECH PATHOLOGY			77	3,766		3,766
053	ELECTROCARDIOLOGY			2,269	19,743		19,743
054	10 CARDIAC REHAB	1		134	2,984		2,984
055	MEDICAL SUPPLIES CHARGED	993		3,295	20,408		20,408
056	DRUGS CHARGED TO PATIENTS		5,537	2,540	35,859		35,859
	OUTPAT SERVICE COST CNTRS						
061	EMERGENCY	199		3,893	101,405		101,405
062	OBSERVATION BEDS (NON-DIS						
063	50 RHC						
	OTHER REIMBURS COST CNTRS						
071	HOME HEALTH AGENCY	41		1,690	67,827		67,827
	SPEC PURPOSE COST CENTERS						
095	SUBTOTALS	2,330	5,537	54,604	956,176		956,176
	NONREIMBURS COST CENTERS						
096	GIFT, FLOWER, COFFEE SHOP				8,338		8,338
098	PHYSICIANS' PRIVATE OFFIC	2			199,188		199,188
100	SENIOR CIRCLE				8,236		8,236
100	01 FREE STANDING NURSING HOM				77,606		77,606
100	02 OTHER NONREIMBURSABLE COS				10,827		10,827
101	CROSS FOOT ADJUSTMENTS						
102	NEGATIVE COST CENTER						
103	TOTAL	2,332	5,537	54,604	1,260,371		1,260,371

COST CENTER DESCRIPTION		OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	RECONCIL- IATION
		(SQUARE FEET	(DOLLAR)VALUE	(SQUARE)FEET	(SQUARE)FEET	(GROSS)SALARIES	
		1	2	3	4	5	6a.00
001	GENERAL SERVICE COST						
002	OLD CAP REL COSTS-BLD						
003	OLD CAP REL COSTS-MVB						
004	NEW CAP REL COSTS-BLD			124,155			
005	NEW CAP REL COSTS-MVB				124,155		
006	EMPLOYEE BENEFITS			1,046	1,046	7,183,307	
008	ADMINISTRATIVE & GENE			19,719	19,719	1,033,878	-3,162,015
009	OPERATION OF PLANT			30,546	30,546	132,253	
010	LAUNDRY & LINEN SERVI			218	218	201	
011	HOUSEKEEPING			1,799	1,799	140,551	
012	DIETARY			5,643	5,643	151	
014	CAFETERIA			2,782	2,782		
015	NURSING ADMINISTRATIO			3,026	3,026	549,876	
016	CENTRAL SERVICES & SU					32,538	
017	PHARMACY					207,491	
025	MEDICAL RECORDS & LIB			2,923	2,923	179,788	
	INPAT ROUTINE SRVC CN						
037	ADULTS & PEDIATRICS			10,866	10,866	855,442	
040	ANCILLARY SRVC COST C						
041	OPERATING ROOM			7,148	7,148	361,487	
044	ANESTHESIOLOGY			209	209		
049	RADIOLOGY-DIAGNOSTIC			5,734	5,734	483,584	
050	LABORATORY			2,804	2,804	386,672	
051	RESPIRATORY THERAPY			735	735	96,091	
052	PHYSICAL THERAPY			3,151	3,151	290,070	
053	OCCUPATIONAL THERAPY			496	496	57,522	
054	SPEECH PATHOLOGY			202	202		
055	ELECTROCARDIOLOGY			987	987	65,118	
056	10 CARDIAC REHAB			176	176	3,083	
061	MEDICAL SUPPLIES CHAR			839	839		
062	DRUGS CHARGED TO PATI			1,415	1,415		
063	OUTPAT SERVICE COST C						
066	EMERGENCY			2,839	2,839	1,407,495	
071	50 OBSERVATION BEDS (NON						
071	RHC						
071	OTHER REIMBURS COST C			3,092	3,092	627,754	
071	HOME HEALTH AGENCY						
095	SPEC PURPOSE COST CEN						
095	SUBTOTALS			108,395	108,395	6,911,045	-3,162,015
096	NONREIMBURS COST CENT			534	534		
098	GIFT, FLOWER, COFFEE			14,131	14,131	22,205	
100	PHYSICIANS' PRIVATE O			522	522	3,720	
100	01 SENIOR CIRCLE					211,723	-301,452
100	02 FREE STANDING NURSING			573	573	34,614	
101	OTHER NONREIMBURSABLE						
102	CROSS FOOT ADJUSTMENT						
103	NEGATIVE COST CENTER						
104	COST TO BE ALLOCATED			461,254	799,117	1,091,134	
104	(WRKSHT B, PART I)						
105	UNIT COST MULTIPLIER			3.715146		.151899	
105	(WRKSHT B, PT I)				6.436446		
106	COST TO BE ALLOCATED						
106	(WRKSHT B, PART II)						
107	UNIT COST MULTIPLIER					10,619	
107	(WRKSHT B, PT II)						
108	COST TO BE ALLOCATED						
108	(WRKSHT B, PART III)						
108	UNIT COST MULTIPLIER					.001478	
108	(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	(NURSING SALARIES)
		6	8	9	10	11	12	14
001	GENERAL SERVICE COST							
002	OLD CAP REL COSTS-BLD							
003	OLD CAP REL COSTS-MVB							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL	13,329,514						
009	OPERATION OF PLANT	1,469,891	68,164					
010	LAUNDRY & LINEN SERVICE	79,184	218	232,515				
011	HOUSEKEEPING	219,609	1,799		70,827			
012	DIETARY	1,252,020	5,643		5,643	153,724		
014	CAFETERIA	28,242	2,782		2,782	26,898	10,611	
015	NURSING ADMINISTRATION	757,876	3,026		3,026		854	2,909,665
016	CENTRAL SERVICES & SUPPLIES	92,253					152	
017	PHARMACY	253,842					234	
025	MEDICAL RECORDS & LIBRARY	365,513	2,923		2,923		616	
037	INPAT ROUTINE SERVICE CENTER							
040	ADULTS & PEDIATRICS	1,553,243	10,866	232,515	10,866	18,147	2,640	855,442
041	ANCILLARY SERVICE CENTER							
044	OPERATING ROOM	604,704	7,148		7,148		753	361,487
049	ANESTHESIOLOGY	22,220	209		209			
050	RADIOLOGY-DIAGNOSTIC	1,265,086	5,734		5,734		1,032	483,584
051	LABORATORY	1,010,069	2,804		2,804		927	386,673
052	RESPIRATORY THERAPY	139,737	735		735		72	96,091
053	PHYSICAL THERAPY	393,315	3,151		3,151		510	
054	OCCUPATIONAL THERAPY	87,798	496		496		99	
055	SPEECH PATHOLOGY	37,490	202		202			
056	ELECTROCARDIOLOGY	121,731	987		987		47	
061	CARDIAC REHAB	5,737	176		176		6	
062	MEDICAL SUPPLIES CHARGED TO PATIENT	208,033	839		839			
063	DRUGS CHARGED TO PATIENT	390,110	1,415		1,415			
066	OUTPAT SERVICE COST CENTER							
067	EMERGENCY	1,640,426	2,839		2,839		1,799	726,388
071	OBSERVATION BEDS (NON RHC)							
071	OTHER REIMBURSABLE COST CENTER							
095	HOME HEALTH AGENCY	992,788	3,092		3,092		400	
095	SPEC PURPOSE COST CENTER							
096	SUBTOTALS	12,990,917	57,084	232,515	55,067	45,045	10,141	2,909,665
098	NONREIMBURSABLE COST CENTER							
100	GIFT, FLOWER, COFFEE	5,421	534		534			
100	PHYSICIANS' PRIVATE OFFICE	231,035	9,451		14,131			
100	SENIOR CIRCLE	10,642	522		522			
100	01 FREE STANDING NURSING					108,679	379	
100	02 OTHER NONREIMBURSABLE	91,499	573		573		91	
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	3,162,015	1,818,577	103,784	319,700	1,725,046	423,563	1,066,139
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)		26.679435		4.513815		39.917350	
105	COST TO BE ALLOCATED (WRKSHT B, PART II)	.237219		.446354		11.221709		.366413
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III)	201,707	332,527	4,474	30,570	106,196	62,024	64,060
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.015132	4.878338	.019242	.431615	.690823	5.845255	.022016

COST CENTER DESCRIPTION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY
	(COSTED REQUIS.	(COSTED)REQUIS.	(GROSS)REVENUE)
	15	16	17
GENERAL SERVICE COST			
001 OLD CAP REL COSTS-BLD			
002 OLD CAP REL COSTS-MVB			
003 NEW CAP REL COSTS-BLD			
004 NEW CAP REL COSTS-MVB			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENE			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVI			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATIO			
015 CENTRAL SERVICES & SU	533,591		
016 PHARMACY	4,764	379,240	
017 MEDICAL RECORDS & LIB	2,698		51,564,812
INPAT ROUTINE SRVC CN			
025 ADULTS & PEDIATRICS	73,343		4,072,553
ANCILLARY SRVC COST C			
037 OPERATING ROOM	80,317		5,112,788
040 ANESTHESIOLOGY	8,587		254,475
041 RADIOLOGY-DIAGNOSTIC	30,831		16,652,347
044 LABORATORY	42,441		9,927,773
049 RESPIRATORY THERAPY	3,780		349,703
050 PHYSICAL THERAPY	3,106		1,696,206
051 OCCUPATIONAL THERAPY	473		374,835
052 SPEECH PATHOLOGY			72,544
053 ELECTROCARDIOLOGY	110		2,142,620
054 10 CARDIAC REHAB	128		126,351
055 MEDICAL SUPPLIES CHAR	227,670		3,111,544
056 DRUGS CHARGED TO PATI		379,240	2,398,710
OUTPAT SERVICE COST C			
061 EMERGENCY	45,491		3,676,406
062 OBSERVATION BEDS (NON			
063 50 RHC			
OTHER REIMBURS COST C			
071 HOME HEALTH AGENCY	9,314		1,595,957
SPEC PURPOSE COST CEN			
095 SUBTOTALS	533,053	379,240	51,564,812
NONREIMBURS COST CENT			
096 GIFT, FLOWER, COFFEE			
098 PHYSICIANS' PRIVATE O	490		
100 SENIOR CIRCLE	48		
100 01 FREE STANDING NURSING			
100 02 OTHER NONREIMBURSABLE			
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 COST TO BE ALLOCATED	120,204	324,472	568,595
(PER WRKSHT B, PART			
104 UNIT COST MULTIPLIER		.855585	
(WRKSHT B, PT I)	.225274		.011027
105 COST TO BE ALLOCATED			
(PER WRKSHT B, PART			
106 UNIT COST MULTIPLIER			
(WRKSHT B, PT II)			
107 COST TO BE ALLOCATED	2,332	5,537	54,604
(PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER		.014600	
(WRKSHT B, PT III)	.004370		.001059

I PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
I 14-1348	I FROM 7/ 1/2007	I WORKSHEET C
I	I TO 6/30/2008	I PART I

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,048,329		3,048,329		3,048,329
37	ANCILLARY SRVC COST CNTRS					
40	OPERATING ROOM	1,208,105		1,208,105		1,208,105
41	ANESTHESIOLOGY	38,750		38,750		38,750
44	RADIOLOGY-DIAGNOSTIC	2,152,995		2,152,995		2,152,995
49	LABORATORY	1,634,863		1,634,863		1,634,863
50	RESPIRATORY THERAPY	238,603		238,603		238,603
51	PHYSICAL THERAPY	624,669		624,669		624,669
52	OCCUPATIONAL THERAPY	132,289		132,289		132,289
53	SPEECH PATHOLOGY	53,484		53,484		53,484
54	ELECTROCARDIOLOGY	206,924		206,924		206,924
55	10 CARDIAC REHAB	14,250		14,250		14,250
56	MEDICAL SUPPLIES CHARGED	369,152		369,152		369,152
	DRUGS CHARGED TO PATIENTS	877,713		877,713		877,713
61	OUTPAT SERVICE COST CNTRS					
62	EMERGENCY	2,506,883		2,506,883		2,506,883
63	50 OBSERVATION BEDS (NON-DIS RHC	21,930		21,930		21,930
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	13,128,939		13,128,939		13,128,939
102	LESS OBSERVATION BEDS	21,930		21,930		21,930
103	TOTAL	13,107,009		13,107,009		13,107,009

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,512,341		5,512,341			
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	1,837,397	4,273,805	6,111,202	.197687	.197687	.197687
41	ANESTHESIOLOGY	102,423	119,475	221,898	.174630	.174630	.174630
44	RADIOLOGY-DIAGNOSTIC	2,061,639	15,629,982	17,691,621	.121696	.121696	.121696
49	LABORATORY	3,100,101	8,397,156	11,497,257	.142196	.142196	.142196
50	RESPIRATORY THERAPY	620,445	70,707	691,152	.345225	.345225	.345225
51	PHYSICAL THERAPY	1,166,411	1,611,396	2,777,807	.224878	.224878	.224878
52	OCCUPATIONAL THERAPY	734,577	52,009	786,586	.168181	.168181	.168181
53	SPEECH PATHOLOGY	117,077	15,260	132,337	.404150	.404150	.404150
54	ELECTROCARDIOLOGY	597,653	1,563,357	2,161,010	.095753	.095753	.095753
55	10 CARDIAC REHAB		27,359	27,359	.520852	.520852	.520852
56	MEDICAL SUPPLIES CHARGED	1,444,279	992,882	2,437,161	.151468	.151468	.151468
61	DRUGS CHARGED TO PATIENTS	1,359,361	1,037,523	2,396,884	.366189	.366189	.366189
62	OUTPAT SERVICE COST CNTRS						
63	EMERGENCY	340,482	3,665,497	4,005,979	.625785	.625785	.625785
101	OBSERVATION BEDS (NON-DIS	1,347	45,268	46,615	.470449	.470449	.470449
102	50 RHC						
103	OTHER REIMBURS COST CNTRS						
	SUBTOTAL	18,995,533	37,501,676	56,497,209			
	LESS OBSERVATION BEDS						
	TOTAL	18,995,533	37,501,676	56,497,209			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,048,329		3,048,329		3,048,329
37	ANCILLARY SRVC COST CNTRS					
40	OPERATING ROOM	1,208,105		1,208,105		1,208,105
41	ANESTHESIOLOGY	38,750		38,750		38,750
44	RADIOLOGY-DIAGNOSTIC	2,152,995		2,152,995		2,152,995
49	LABORATORY	1,634,863		1,634,863		1,634,863
50	RESPIRATORY THERAPY	238,603		238,603		238,603
51	PHYSICAL THERAPY	624,669		624,669		624,669
52	OCCUPATIONAL THERAPY	132,289		132,289		132,289
53	SPEECH PATHOLOGY	53,484		53,484		53,484
54	ELECTROCARDIOLOGY	206,924		206,924		206,924
55	10 CARDIAC REHAB	14,250		14,250		14,250
56	MEDICAL SUPPLIES CHARGED	369,152		369,152		369,152
	DRUGS CHARGED TO PATIENTS	877,713		877,713		877,713
61	OUTPAT SERVICE COST CNTRS					
62	EMERGENCY	2,506,883		2,506,883		2,506,883
63	50 OBSERVATION BEDS (NON-DIS RHC	21,930		21,930		21,930
101	OTHER REIMBURS COST CNTRS					
102	SUBTOTAL	13,128,939		13,128,939		13,128,939
103	LESS OBSERVATION BEDS	21,930		21,930		21,930
	TOTAL	13,107,009		13,107,009		13,107,009

I PROVIDER NO:

I PERIOD:

I PREPARED 11/25/2008

COMPUTATION OF RATIO OF COSTS TO CHARGES

I 14-1348

I FROM 7/ 1/2007

I WORKSHEET C

SPECIAL TITLE XIX WORKSHEET

I

I TO 6/30/2008

I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,512,341		5,512,341			
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	1,837,397	4,273,805	6,111,202	.197687	.197687	.197687
41	ANESTHESIOLOGY	102,423	119,475	221,898	.174630	.174630	.174630
44	RADIOLOGY-DIAGNOSTIC	2,061,639	15,629,982	17,691,621	.121696	.121696	.121696
49	LABORATORY	3,100,101	8,397,156	11,497,257	.142196	.142196	.142196
50	RESPIRATORY THERAPY	620,445	70,707	691,152	.345225	.345225	.345225
51	PHYSICAL THERAPY	1,166,411	1,611,396	2,777,807	.224878	.224878	.224878
52	OCCUPATIONAL THERAPY	734,577	52,009	786,586	.168181	.168181	.168181
53	SPEECH PATHOLOGY	117,077	15,260	132,337	.404150	.404150	.404150
54	ELECTROCARDIOLOGY	597,653	1,563,357	2,161,010	.095753	.095753	.095753
55	10 CARDIAC REHAB		27,359	27,359	.520852	.520852	.520852
56	MEDICAL SUPPLIES CHARGED	1,444,279	992,882	2,437,161	.151468	.151468	.151468
61	DRUGS CHARGED TO PATIENTS	1,359,361	1,037,523	2,396,884	.366189	.366189	.366189
62	OUTPAT SERVICE COST CNTRS						
63	EMERGENCY	340,482	3,665,497	4,005,979	.625785	.625785	.625785
101	50 OBSERVATION BEDS (NON-DIS	1,347	45,268	46,615	.470449	.470449	.470449
102	RHC						
103	OTHER REIMBURS COST CNTRS						
	SUBTOTAL	18,995,533	37,501,676	56,497,209			
	LESS OBSERVATION BEDS						
	TOTAL	18,995,533	37,501,676	56,497,209			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	1,208,105	138,327	1,069,778			1,208,105
41	ANESTHESIOLOGY	38,750	3,874	34,876			38,750
44	RADIOLOGY-DIAGNOSTIC	2,152,995	142,962	2,010,033			2,152,995
49	LABORATORY	1,634,863	83,841	1,551,022			1,634,863
50	RESPIRATORY THERAPY	238,603	16,546	222,057			238,603
51	PHYSICAL THERAPY	624,669	59,891	564,778			624,669
52	OCCUPATIONAL THERAPY	132,289	10,061	122,228			132,289
53	SPEECH PATHOLOGY	53,484	3,766	49,718			53,484
54	ELECTROCARDIOLOGY	206,924	19,743	187,181			206,924
55	10 CARDIAC REHAB	14,250	2,984	11,266			14,250
56	MEDICAL SUPPLIES CHARGED	369,152	20,408	348,744			369,152
61	DRUGS CHARGED TO PATIENTS	877,713	35,859	841,854			877,713
62	OUTPAT SERVICE COST CNTRS						
63	EMERGENCY	2,506,883	101,405	2,405,478			2,506,883
101	50 OBSERVATION BEDS (NON-DIS	21,930		21,930			21,930
102	RHC						
103	OTHER REIMBURS COST CNTRS						
	SUBTOTAL	10,080,610	639,667	9,440,943			10,080,610
	LESS OBSERVATION BEDS	21,930		21,930			21,930
	TOTAL	10,058,680	639,667	9,419,013			10,058,680

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	6,111,202	.197687	.197687
40	ANESTHESIOLOGY	221,898	.174630	.174630
41	RADIOLOGY-DIAGNOSTIC	17,691,621	.121696	.121696
44	LABORATORY	11,497,257	.142196	.142196
49	RESPIRATORY THERAPY	691,152	.345225	.345225
50	PHYSICAL THERAPY	2,777,807	.224878	.224878
51	OCCUPATIONAL THERAPY	786,586	.168181	.168181
52	SPEECH PATHOLOGY	132,337	.404150	.404150
53	ELECTROCARDIOLOGY	2,161,010	.095753	.095753
54	10 CARDIAC REHAB	27,359	.520852	.520852
55	MEDICAL SUPPLIES CHARGED	2,437,161	.151468	.151468
56	DRUGS CHARGED TO PATIENTS	2,396,884	.366189	.366189
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,005,979	.625785	.625785
62	OBSERVATION BEDS (NON-DIS	46,615	.470449	.470449
63	50 RHC			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	50,984,868		
102	LESS OBSERVATION BEDS	46,615		
103	TOTAL	50,938,253		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	1,208,105	138,327	1,069,778			1,208,105
41	ANESTHESIOLOGY	38,750	3,874	34,876			38,750
44	RADIOLOGY-DIAGNOSTIC	2,152,995	142,962	2,010,033			2,152,995
49	LABORATORY	1,634,863	83,841	1,551,022			1,634,863
50	RESPIRATORY THERAPY	238,603	16,546	222,057			238,603
51	PHYSICAL THERAPY	624,669	59,891	564,778			624,669
52	OCCUPATIONAL THERAPY	132,289	10,061	122,228			132,289
53	SPEECH PATHOLOGY	53,484	3,766	49,718			53,484
54	ELECTROCARDIOLOGY	206,924	19,743	187,181			206,924
55	10 CARDIAC REHAB	14,250	2,984	11,266			14,250
56	MEDICAL SUPPLIES CHARGED	369,152	20,408	348,744			369,152
	DRUGS CHARGED TO PATIENTS	877,713	35,859	841,854			877,713
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,506,883	101,405	2,405,478			2,506,883
62	OBSERVATION BEDS (NON-DIS	21,930		21,930			21,930
63	50 RHC						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	10,080,610	639,667	9,440,943			10,080,610
102	LESS OBSERVATION BEDS	21,930		21,930			21,930
103	TOTAL	10,058,680	639,667	9,419,013			10,058,680

Health Financial Systems	MCRIF32	FOR RED BUD REGIONAL HOSPITAL	***NOT A CMS WORKSHEET **	(09/2000)
CALCULATION OF OUTPATIENT SERVICE COST TO	I	PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
CHARGE RATIOS NET OF REDUCTIONS	I	14-1348	I FROM 7/ 1/2007	I WORKSHEET C
SPECIAL TITLE XIX WORKSHEET	I		I TO 6/30/2008	I PART II

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	6,111,202	.197687	.197687
40	ANESTHESIOLOGY	221,898	.174630	.174630
41	RADIOLOGY-DIAGNOSTIC	17,691,621	.121696	.121696
44	LABORATORY	11,497,257	.142196	.142196
49	RESPIRATORY THERAPY	691,152	.345225	.345225
50	PHYSICAL THERAPY	2,777,807	.224878	.224878
51	OCCUPATIONAL THERAPY	786,586	.168181	.168181
52	SPEECH PATHOLOGY	132,337	.404150	.404150
53	ELECTROCARDIOLOGY	2,161,010	.095753	.095753
54	10 CARDIAC REHAB	27,359	.520852	.520852
55	MEDICAL SUPPLIES CHARGED	2,437,161	.151468	.151468
56	DRUGS CHARGED TO PATIENTS	2,396,884	.366189	.366189
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,005,979	.625785	.625785
62	OBSERVATION BEDS (NON-DIS	46,615	.470449	.470449
63	50 RHC			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	50,984,868		
102	LESS OBSERVATION BEDS	46,615		
103	TOTAL	50,938,253		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,208,105	6,111,202			
40	ANESTHESIOLOGY	38,750	221,898			
41	RADIOLOGY-DIAGNOSTIC	2,152,995	17,691,621			
44	LABORATORY	1,634,863	11,497,257			
49	RESPIRATORY THERAPY	238,603	691,152			
50	PHYSICAL THERAPY	624,669	2,777,807			
51	OCCUPATIONAL THERAPY	132,289	786,586			
52	SPEECH PATHOLOGY	53,484	132,337			
53	ELECTROCARDIOLOGY	206,924	2,161,010			
54	10 CARDIAC REHAB	14,250	27,359			
55	MEDICAL SUPPLIES CHARGED	369,152	2,437,161			
56	DRUGS CHARGED TO PATIENTS	877,713	2,396,884			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,506,883	4,005,979			
62	OBSERVATION BEDS (NON-DIS	21,930	46,615			
63	50 RHC					
	OTHER REIMBURS COST CNTRS					
101	TOTAL	10,080,610	50,984,868			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/25/2008
I	14-1348	I	FROM 7/ 1/2007	I	WORKSHEET C
I		I	TO 6/30/2008	I	PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS	1,208,105		1,208,105	6,111,202			
40	OPERATING ROOM	38,750		38,750	221,898			
41	ANESTHESIOLOGY	2,152,995		2,152,995	17,691,621			
44	RADIOLOGY-DIAGNOSTIC	1,634,863	82,571	1,717,434	11,497,257			
49	LABORATORY	238,603		238,603	691,152			
50	RESPIRATORY THERAPY	624,669		624,669	2,777,807			
51	PHYSICAL THERAPY	132,289		132,289	786,586			
52	OCCUPATIONAL THERAPY	53,484		53,484	132,337			
53	SPEECH PATHOLOGY	206,924	15,769	222,693	2,161,010			
54	ELECTROCARDIOLOGY	14,250		14,250	27,359			
55	10 CARDIAC REHAB	369,152		369,152	2,437,161			
56	MEDICAL SUPPLIES CHARGED	877,713		877,713	2,396,884			
	DRUGS CHARGED TO PATIENTS							
61	OUTPAT SERVICE COST CNTRS							
62	EMERGENCY	2,506,883	430,347	2,937,230	4,005,979			
63	OBSERVATION BEDS (NON-DIS	21,930		21,930	46,615			
63	50 RHC							
101	OTHER REIMBURS COST CNTRS							
102	TOTAL	10,080,610	528,687	10,609,297	50,984,868			
103	TOTAL OUTPATIENT VISITS							
104	AGGREGATE COST PER VISIT							
105	TITLE V OUTPATIENT VISITS							
106	TITLE XVIII OUTPAT VISITS							
107	TITLE XIX OUTPAT VISITS							
108	TITLE V OUTPAT COSTS							
109	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B

HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description		1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.197687		.197687		
40	ANESTHESIOLOGY	.174630		.174630		
41	RADIOLOGY-DIAGNOSTIC	.121696		.121696		
44	LABORATORY	.142196		.142196		
49	RESPIRATORY THERAPY	.345225		.345225		
50	PHYSICAL THERAPY	.224878		.224878		
51	OCCUPATIONAL THERAPY	.168181		.168181		
52	SPEECH PATHOLOGY	.404150		.404150		
53	ELECTROCARDIOLOGY	.095753		.095753		
54	10 CARDIAC REHAB	.520852		.520852		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.151468		.151468		
56	DRUGS CHARGED TO PATIENTS	.366189		.366189		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.625785		.625785		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.470449		.470449		
63	50 RHC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

Cost Center Description		Other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		1,233,624			
40	ANESTHESIOLOGY		29,433			
41	RADIOLOGY-DIAGNOSTIC		5,445,008			
44	LABORATORY		3,796,464			
49	RESPIRATORY THERAPY		32,597			
50	PHYSICAL THERAPY		586,358			
51	OCCUPATIONAL THERAPY		19,369			
52	SPEECH PATHOLOGY		9,015			
53	ELECTROCARDIOLOGY		795,233			
54	10 CARDIAC REHAB		19,534			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		256,284			
56	DRUGS CHARGED TO PATIENTS		401,878			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		1,302,479			
62	OBSERVATION BEDS (NON-DISTINCT PART)		3,627			
63	50 RHC					
101	SUBTOTAL		13,930,903			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		13,930,903			

TITLE XVIII, PART B

HOSPITAL

All other

Hospital I/P
Part B Charges

Hospital I/P
Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	243,871		
40 ANESTHESIOLOGY	5,140		
41 RADIOLOGY-DIAGNOSTIC	662,636		
44 LABORATORY	539,842		
49 RESPIRATORY THERAPY	11,253		
50 PHYSICAL THERAPY	131,859		
51 OCCUPATIONAL THERAPY	3,257		
52 SPEECH PATHOLOGY	3,643		
53 ELECTROCARDIOLOGY	76,146		
54 10 CARDIAC REHAB	10,174		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,819		
56 DRUGS CHARGED TO PATIENTS	147,163		
OUTPAT SERVICE COST CNTRS			
61 EMERGENCY	815,072		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1,706		
63 50 RHC			
101 SUBTOTAL	2,690,581		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-			
PROGRAM ONLY CHARGES			
104 NET CHARGES	2,690,581		

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.366189
2	PROGRAM VACCINE CHARGES		1,080
3	PROGRAM COSTS		395

TITLE XVIII PART A

HOSPITAL

OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,260
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,321
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	41
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,280
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2,717
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	230
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	-8
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,316
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2,717
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	24
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	169.46
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,048,329
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	38,976
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,393,129
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,655,200

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,047,306
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	46,223
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,001,083
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.408963
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	1,127.39
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,219.84
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,655,200

TITLE XVIII PART A

HOSPITAL

OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	498.40
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,154,294
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,154,294

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				990,239
49	TOTAL PROGRAM INPATIENT COSTS				2,144,533

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	1,354,153
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	1,354,153
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A	HOSPITAL	OTHER
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PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE
SERVICE COST
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
68 PROGRAM ROUTINE SERVICE COST
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS
72 PER DIEM CAPITAL-RELATED COSTS
73 PROGRAM CAPITAL-RELATED COSTS
74 INPATIENT ROUTINE SERVICE COST
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS
76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION
78 INPATIENT ROUTINE SERVICE COST LIMITATION
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS
80 PROGRAM INPATIENT ANCILLARY SERVICES
81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	44
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	498.40
85	OBSERVATION BED COST	21,930

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XVIII PART A

SNF

OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

- 1 INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)
- 2 INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)
- 3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)
- 4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)
- 5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)
- 6 THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
- 7 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER
- 8 DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)
- 9 TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)
- 10 THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
- 11 TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER
- 12 DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)
- 13 TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM
- 14 (EXCLUDING SWING-BED AND NEWBORN DAYS)
- 15 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING
- 16 PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
- 17 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING
- 18 PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR
- 19 YEAR, ENTER 0 ON THIS LINE)
- 20 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING
- 21 PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
- 22 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING
- 23 PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR
- 24 YEAR, ENTER 0 ON THIS LINE)
- 25 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM
- 26 (EXCLUDING SWING-BED DAYS)
- 27 TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)
- 28 NURSERY DAYS (TITLE V OR XIX ONLY)

SWING-BED ADJUSTMENT

- 17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH
- 18 DECEMBER 31 OF THE COST REPORTING PERIOD
- 19 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER
- 20 DECEMBER 31 OF THE COST REPORTING PERIOD
- 21 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH
- 22 DECEMBER 31 OF THE COST REPORTING PERIOD
- 23 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER
- 24 DECEMBER 31 OF THE COST REPORTING PERIOD
- 25 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST
- 26 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST
- 27 REPORTING PERIOD
- 28 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST
- 29 REPORTING PERIOD
- 30 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST
- 31 REPORTING PERIOD
- 32 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST
- 33 REPORTING PERIOD
- 34 TOTAL SWING-BED COST (SEE INSTRUCTIONS)
- 35 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

- 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)
- 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)
- 30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)
- 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO
- 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE
- 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE
- 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL
- 35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL
- 36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT
- 37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM
- 38 COST DIFFERENTIAL

TITLE XVIII PART A	SNF	OTHER
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PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

1

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
68	PROGRAM ROUTINE SERVICE COST
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS
72	PER DIEM CAPITAL-RELATED COSTS
73	PROGRAM CAPITAL-RELATED COSTS
74	INPATIENT ROUTINE SERVICE COST
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION
78	INPATIENT ROUTINE SERVICE COST LIMITATION
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS
80	PROGRAM INPATIENT ANCILLARY SERVICES
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION
82	TOTAL PROGRAM INPATIENT OPERATING COSTS

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
85	OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/25/2008
I	14-1348	I	FROM 7/ 1/2007	I	WORKSHEET D-4
I	COMPONENT NO:	I	TO 6/30/2008	I	
I	14-1348	I		I	

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
LINE NO.		TO CHARGES	CHARGES	COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS			
	ADULTS & PEDIATRICS		2,677,619	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.197687	483,409	95,564
40	ANESTHESIOLOGY	.174630	46,830	8,178
41	RADIOLOGY-DIAGNOSTIC	.121696	828,803	100,862
44	LABORATORY	.142196	1,600,890	227,640
49	RESPIRATORY THERAPY	.345225	320,799	110,748
50	PHYSICAL THERAPY	.224878	180,532	40,598
51	OCCUPATIONAL THERAPY	.168181	56,722	9,540
52	SPEECH PATHOLOGY	.404150	38,979	15,753
53	ELECTROCARDIOLOGY	.095753	396,494	37,965
54	10 CARDIAC REHAB	.520852		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.151468	657,736	99,626
56	DRUGS CHARGED TO PATIENTS	.366189	655,019	239,861
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.625785	6,239	3,904
62	OBSERVATION BEDS (NON-DISTINCT PART)	.470449		
63	50 RHC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		5,272,452	990,239
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		5,272,452	

TITLE XVIII, PART A		SWING BED SNF		OTHER	
WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
25	INPAT ROUTINE SRVC CNTRS				
	ADULTS & PEDIATRICS				
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	.197687	32,428	6,411	
40	ANESTHESIOLOGY	.174630			
41	RADIOLOGY-DIAGNOSTIC	.121696	171,037	20,815	
44	LABORATORY	.142196	399,422	56,796	
49	RESPIRATORY THERAPY	.345225	187,349	64,678	
50	PHYSICAL THERAPY	.224878	909,260	204,473	
51	OCCUPATIONAL THERAPY	.168181	632,790	106,423	
52	SPEECH PATHOLOGY	.404150	69,241	27,984	
53	ELECTROCARDIOLOGY	.095753	41,428	3,967	
54	10 CARDIAC REHAB	.520852			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.151468	197,087	29,852	
56	DRUGS CHARGED TO PATIENTS	.366189	289,871	106,148	
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY	.625785			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.470449			
63	50 RHC				
	OTHER REIMBURS COST CNTRS				
101	TOTAL		2,929,913	627,547	
102	LESS PBP CLINIC LABORATORY SERVICES -				
	PROGRAM ONLY CHARGES				
103	NET CHARGES		2,929,913		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
I 14-1348	I FROM 7/ 1/2007	I WORKSHEET E
I COMPONENT NO:	I TO 6/30/2008	I PART B
I 14-1348	I	I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,690,976
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04 LINE 1.01 TIMES LINE 1.03.	
1.05 LINE 1.02 DIVIDED BY LINE 1.04.	
1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07 ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2 INTERNS AND RESIDENTS	
3 ORGAN ACQUISITIONS	
4 COST OF TEACHING PHYSICIANS	
5 TOTAL COST (SEE INSTRUCTIONS)	2,690,976

COMPUTATION OF LESSER OF COST OR CHARGES

6 REASONABLE CHARGES	
7 ANCILLARY SERVICE CHARGES	
8 INTERNS AND RESIDENTS SERVICE CHARGES	
9 ORGAN ACQUISITION CHARGES	
10 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10 TOTAL REASONABLE CHARGES	
11 CUSTOMARY CHARGES	
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13 RATIO OF LINE 11 TO LINE 12	
14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	2,717,886
17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES	38,118
18.01 CAH ACTUAL BILLED COINSURANCE	2,031,536
LINE 17.01 (SEE INSTRUCTIONS)	
19 SUBTOTAL (SEE INSTRUCTIONS)	648,232
20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22 ESRD DIRECT MEDICAL EDUCATION COSTS	
23 SUBTOTAL	648,232
24 PRIMARY PAYER PAYMENTS	319
25 SUBTOTAL	647,913

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD	
27 BAD DEBTS (SEE INSTRUCTIONS)	214,577
27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	214,577
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	208,986
28 SUBTOTAL	862,490
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30 OTHER ADJUSTMENTS (SPECIFY)	
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32 SUBTOTAL	862,490
33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34 INTERIM PAYMENTS	1,195,932
34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35 BALANCE DUE PROVIDER/PROGRAM	-333,442
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TITLE XVIII

HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	3	4
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		1,871,761 NONE		1,195,932 NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01	1/14/2008		118,300
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50			
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99			118,300
4 TOTAL INTERIM PAYMENTS		1,990,061		NONE 1,195,932
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99	NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER	.01			
SETTLEMENT TO PROGRAM	.02			
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ____/____/____

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	3	4
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		2,026,414		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	1/14/2008	140,300		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		140,300		NONE
4 TOTAL INTERIM PAYMENTS		2,166,714		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) .01				
BASED ON COST REPORT (1) SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ____/____/____

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,367,695	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	633,822	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	2,717	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	2,001,517	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	2,001,517	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	2,001,517	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	86,788	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,914,729	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,914,729	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	2,166,714	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-251,985	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/25/2008
I	14-1348	I	FROM 7/ 1/2007	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2008	I	PART II
I	14-1348	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	2,144,533
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,144,533
5	PRIMARY PAYER PAYMENTS	6,221
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,159,695

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,159,695
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	457,984
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,701,711
23	COINSURANCE	
24	SUBTOTAL	1,701,711
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	49,419
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	49,419
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	48,478
26	SUBTOTAL	1,751,130
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,751,130
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,990,061
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-238,931
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
I 14-1348	I FROM 7/ 1/2007	I WORKSHEET E-3
I COMPONENT NO:	I TO 6/30/2008	I PART II
I -	I	I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
SNF

1 INPATIENT SERVICES
 1.01 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT
 2 ORGAN ACQUISITION
 3 COST OF TEACHING PHYSICIANS
 4 SUBTOTAL
 5 PRIMARY PAYER PAYMENTS
 6 TOTAL COST. FOR CAH (SEE INSTRUCTIONS)

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES
 7 ROUTINE SERVICE CHARGES
 8 ANCILLARY SERVICE CHARGES
 9 ORGAN ACQUISITION CHARGES, NET OF REVENUE
 10 TEACHING PHYSICIANS
 11 TOTAL REASONABLE CHARGES

CUSTOMARY CHARGES
 12 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
 13 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)
 14 RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)
 15 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
 16 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
 17 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES

COMPUTATION OF REIMBURSEMENT SETTLEMENT
 18 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
 19 COST OF COVERED SERVICES
 20 DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)
 21 EXCESS REASONABLE COST
 22 SUBTOTAL
 23 COINSURANCE
 24 SUBTOTAL
 25 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL
 SERVICES (SEE INSTRUCTIONS)
 25.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)
 25.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
 26 SUBTOTAL
 27 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER
 TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
 28 LOSS ON SALE OF ASSETS
 29 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS
 RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
 30 SUBTOTAL
 31 SEQUESTRATION ADJUSTMENT
 32 INTERIM PAYMENTS
 32.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 33 BALANCE DUE PROVIDER/PROGRAM
 34 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	214,707			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE	3,404,944			
4 ACCOUNTS RECEIVABLE				
5 OTHER RECEIVABLES	-45,990			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-251,999			
7 INVENTORY	357,238			
8 PREPAID EXPENSES	145,279			
9 OTHER CURRENT ASSETS	4,425			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	3,828,604			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS	116,812			
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	2,328,882			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS	13,854			
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	3,908,473			
18.01 LESS ACCUMULATED DEPRECIATION	-3,112,823			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE	9,417			
21 TOTAL FIXED ASSETS	3,264,615			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	135,994			
26 TOTAL OTHER ASSETS	135,994			
27 TOTAL ASSETS	7,229,213			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	672,377			
29 SALARIES, WAGES & FEES PAYABLE	504,562			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	87,511			
36 TOTAL CURRENT LIABILITIES	1,264,450			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	10,017,015			
42 TOTAL LONG-TERM LIABILITIES	10,017,015			
43 TOTAL LIABILITIES	11,281,465			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	-4,052,252			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	-4,052,252			
52 TOTAL LIABILITIES AND FUND BALANCES	7,229,213			

	GENERAL FUND	SPECIFIC PURPOSE FUND
	1	2 3 4
1 FUND BALANCE AT BEGINNING		-7,557,991
2 OF PERIOD		
3 NET INCOME (LOSS)		1,494,458
4 TOTAL		-6,063,533
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 2,011,281		
7		
8		
9		
10 TOTAL ADDITIONS		2,011,281
11 SUBTOTAL		-4,052,252
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		-4,052,252
PERIOD PER BALANCE SHEET		

	ENDOWMENT FUND	PLANT FUND
	5 6	7 8
1 FUND BALANCE AT BEGINNING		
2 OF PERIOD		
3 NET INCOME (LOSS)		
4 TOTAL		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		
PERIOD PER BALANCE SHEET		

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PROVIDER NO:

14-1348

I PERIOD:

I FROM 7/ 1/2007

I TO 6/30/2008

I PREPARED 11/25/2008

I WORKSHEET G-2

I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
4 00 HOSPITAL	5,512,341		5,512,341
5 00 SWING BED - SNF			
9 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	5,512,341		5,512,341
15 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
16 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	5,512,341		5,512,341
17 00 TOTAL INPATIENT ROUTINE CARE SERVICE	13,483,191		13,483,191
18 00 ANCILLARY SERVICES			
18 00 OUTPATIENT SERVICES		37,501,676	37,501,676
18 50 RHC			
19 00 HOME HEALTH AGENCY		1,595,957	1,595,957
24 00 ER CRNA REVENUE	729,768	1,015,081	1,744,849
25 00 TOTAL PATIENT REVENUES	19,725,300	40,112,714	59,838,014

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		19,963,718
ADD (SPECIFY)		
27 00		
28 00		
29 00		
30 00		
31 00		
32 00		
33 00 TOTAL ADDITIONS		
DEDUCT (SPECIFY)		
34 00	1	
35 00		
36 00		
37 00		
38 00		
39 00 TOTAL DEDUCTIONS		1
40 00 TOTAL OPERATING EXPENSES		19,963,717

DESCRIPTION

1	TOTAL PATIENT REVENUES	59,838,014
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	38,617,329
3	NET PATIENT REVENUES	21,220,685
4	LESS: TOTAL OPERATING EXPENSES	19,963,717
5	NET INCOME FROM SERVICE TO PATIENTS	1,256,968
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	23,703
7	INCOME FROM INVESTMENTS	3,358
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	94,584
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	3,495
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	333
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	35
22	RENTAL OF HOSPITAL SPACE	90,338
23	GOVERNMENTAL APPROPRIATIONS	15,395
24	GAIN ON SALE OF ASSETS	500
24.01	INSERVICE ED CLASSES	400
24.02	MISCELLANEOUS	5,349
25	TOTAL OTHER INCOME	237,490
26	TOTAL	1,494,458
	OTHER EXPENSES	
27		
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,494,458

Health Financial Systems MCRIF32
ANALYSIS OF PROVIDER-BASED
HOME HEALTH AGENCY COSTS

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
I 14-1348 I FROM 7/ 1/2007 I WORKSHEET H
I HHA NO: I TO 6/30/2008 I
I 14-7486 I

HHA 1

SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION	CONTRACTED/ PURCHASED SVCS	OTHER COSTS	TOTAL
1	2	3	4	5	6

GENERAL SERVICE COST CENTERS					
1	CAP-REL COST-BLDG & FIX				
2	CAP-REL COST-MOV EQUIP				
3	PLANT OPER & MAINT				
4	TRANSPORTATION				
5	ADMIN & GENERAL	142,726	94,340	59,176	39,018
	HHA REIMBURSABLE SERVICES				12,190
6	SKILLED NURSING CARE	249,317			
7	PHYSICAL THERAPY	195,175			
8	OCCUPATIONAL THERAPY	36,261			
9	SPEECH PATHOLOGY			8,392	
10	MEDICAL SOCIAL SERVICES				
11	HOME HEALTH AIDE	4,275			
12	SUPPLIES				
13	DRUGS				
13.20	COST ADMINISTERING DRUGS				
14	DME				
HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SVCS				
16	RESPIRATORY THERAPY				
17	PRIVATE DUTY NURSING				
18	CLINIC				
19	HEALTH PROM ACTIVITIES				
20	DAY CARE PROGRAM				
21	HOME DEL MEALS PROGRAM				
22	HOMEMAKER SERVICE				
23	ALL OTHER				
23.50	TELEMEDICINE				
24	TOTAL (SUM OF LINES 1-23)	627,754	94,340	59,176	47,410
					12,190
					840,870

RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION
7	8	9	10

GENERAL SERVICE COST CENTERS			
1	CAP-REL COST-BLDG & FIX		
2	CAP-REL COST-MOV EQUIP		
3	PLANT OPER & MAINT		
4	TRANSPORTATION		
5	ADMIN & GENERAL	-28,782	318,668
	HHA REIMBURSABLE SERVICES		47,398
6	SKILLED NURSING CARE		366,066
7	PHYSICAL THERAPY		249,317
8	OCCUPATIONAL THERAPY		195,175
9	SPEECH PATHOLOGY	6,559	36,261
10	MEDICAL SOCIAL SERVICES		14,951
11	HOME HEALTH AIDE		14,951
12	SUPPLIES		
13	DRUGS		
13.20	COST ADMINISTERING DRUGS		
14	DME		
HHA NONREIMBURSABLE SERVICES			
15	HOME DIALYSIS AIDE SVCS		
16	RESPIRATORY THERAPY		
17	PRIVATE DUTY NURSING		
18	CLINIC		
19	HEALTH PROM ACTIVITIES		
20	DAY CARE PROGRAM		
21	HOME DEL MEALS PROGRAM		
22	HOMEMAKER SERVICE		
23	ALL OTHER		
23.50	TELEMEDICINE		
24	TOTAL (SUM OF LINES 1-23)	-22,223	818,647
			47,398
			866,045

Health Financial Systems MCRIF32
COST ALLOCATION -
HHA GENERAL SERVICE COST

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)
I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
I 14-1348 I FROM 7/ 1/2007 I WORKSHEET H-4
I HHA NO: I TO 6/30/2008 I PART I
I 14-7486 I

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
13.20							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24							
HHA REIMBURSABLE SERVICES							
6							
7							
8							
9							
10							
11							
12							
13							
13.20							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24							
TOTAL (SUM OF LINES 1-23)							

TOTAL

6

GENERAL SERVICE COST CENTERS		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
13.20		
14		
HHA REIMBURSABLE SERVICES		
6		
7		
8		
9		
10		
11		
12		
13		
13.20		
14		
HHA NONREIMBURSABLE SERVICES		
15		
16		
17		
18		
19		
20		
21		
22		
23		
23.50		
24		
TOTAL (SUM OF LINES 1-23)		

Health Financial Systems
COST ALLOCATION -
HHA STATISTICAL BASIS

MCRIF32

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I PROVIDER NO:	I PERIOD:	I PREPARED 11/25/2008
I 14-1348	I FROM 7/ 1/2007	I WORKSHEET H-4
I HHA NO:	I TO 6/30/2008	I PART II
I 14-7486	I	I

HHA 1

	CAP-REL COST-BLDG & FIX (SQUARE FEET)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (SQUARE FEET)	TRANSPORTATIO N (MILEAGE)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUM. COST)
	1	2	3	4	5A	5
GENERAL SERVICE COST CENTERS						
1 CAP-REL COST-BLDG & FIX						
2 CAP-REL COST-MOV EQUIP						
3 PLANT OPER & MAINT						
4 TRANSPORTATION						
5 ADMINISTRATIVE & GENERAL					-366,066	499,979
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE						249,317
7 PHYSICAL THERAPY						195,175
8 OCCUPATIONAL THERAPY						36,261
9 SPEECH PATHOLOGY						14,951
10 MEDICAL SOCIAL SERVICES						
11 HOME HEALTH AIDE						4,275
12 SUPPLIES						
13 DRUGS						
13.20 COST ADMINISTERING DRUGS						
14 DME						
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SVCS						
16 RESPIRATORY THERAPY						
17 PRIVATE DUTY NURSING						
18 CLINIC						
19 HEALTH PROM ACTIVITIES						
20 DAY CARE PROGRAM						
21 HOME DEL MEALS PROGRAM						
22 HOMEMAKER SERVICE						
23 ALL OTHERS						
23.50 TELEMEDICINE						
24 TOTAL (SUM OF LINES 1-23)					-366,066	499,979
25 COST TO BE ALLOCATED						366,066
26 UNIT COST MULTIPLIER						.732163

Health Financial Systems MCRIF32
ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
I 14-1348 I FROM 7/ 1/2007 I WORKSHEET H-5
I HHA NO: I TO 6/30/2008 I PART I
I 14-7486 I

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	OLD CAP REL COSTS-BLDG & 1	OLD CAP REL COSTS-MVBLE 2	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BEN EFITS 5
1 ADMIN & GENERAL				11,487	19,901	95,355
2 SKILLED NURSING CARE	431,857					
3 PHYSICAL THERAPY	338,075					
4 OCCUPATIONAL THERAPY	62,810					
5 SPEECH PATHOLOGY	25,898					
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	7,405					
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	866,045			11,487	19,901	95,355
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11
1 ADMIN & GENERAL	126,743	30,066	82,493		13,957	
2 SKILLED NURSING CARE	431,857	102,444				
3 PHYSICAL THERAPY	338,075	80,198				
4 OCCUPATIONAL THERAPY	62,810	14,900				
5 SPEECH PATHOLOGY	25,898	6,143				
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	7,405	1,757				
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	992,788	235,508	82,493		13,957	
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

Health Financial Systems MCRIF32
 ALLOCATION OF GENERAL SERVICE
 COSTS TO HHA COST CENTERS

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)
 PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
 14-1348 I FROM 7/ 1/2007 I WORKSHEET H-5
 HHA NO: I TO 6/30/2008 I PART I
 14-7486 I

HHA 1

HHA COST CENTER	CAFETERIA 12	NURSING ADMINISTRATION 14	CENTRAL SERVICES & SUPPLIES 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SUBTOTAL 25
1 ADMIN & GENERAL	15,967		2,098		17,599	288,923
2 SKILLED NURSING CARE						534,301
3 PHYSICAL THERAPY						418,273
4 OCCUPATIONAL THERAPY						77,710
5 SPEECH PATHOLOGY						32,041
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						9,162
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	15,967		2,098		17,599	1,360,410
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	POST STEP DOWN ADJUST 26	SUBTOTAL 27	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL		288,923		
2 SKILLED NURSING CARE		534,301	144,072	678,373
3 PHYSICAL THERAPY		418,273	112,786	531,059
4 OCCUPATIONAL THERAPY		77,710	20,954	98,664
5 SPEECH PATHOLOGY		32,041	8,640	40,681
6 MEDICAL SOCIAL SERVICES				
7 HOME HEALTH AIDE		9,162	2,471	11,633
8 SUPPLIES				
9 DRUGS				
9.20 COST ADMINISTERING DRUGS				
10 DME				
11 HOME DIALYSIS AIDE SVCS				
12 RESPIRATORY THERAPY				
13 PRIVATE DUTY NURSING				
14 CLINIC				
15 HEALTH PROM ACTIVITIES				
16 DAY CARE PROGRAM				
17 HOME DEL MEALS PROGRAM				
18 HOMEMAKER SERVICE				
19 ALL OTHER				
19.50 TELEMEDICINE				
20 TOTAL (SUM OF 1-19) (2)		1,360,410	288,923	1,360,410
21 UNIT COST MULTIPLIER			0.269647	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

Health Financial Systems MCRIF32
 ALLOCATION OF GENERAL SERVICE
 COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
 I 14-1348 I FROM 7/ 1/2007 I WORKSHEET H-5
 I HHA NO: I TO 6/30/2008 I PART II
 I 14-7486 I

HHA 1

HHA COST CENTER	OLD CAP REL COSTS-BLDG & (SQUARE FEET	OLD CAP REL COSTS-MVBLE (DOLLAR VALUE	NEW CAP REL COSTS-BLDG & (SQUARE FEET	NEW CAP REL COSTS-MVBLE (SQUARE FEET	EMPLOYEE BEN EFITS (GROSS SALARIES	RECONCILIATI ON
	1	2	3	4	5	6A
1 ADMIN & GENERAL			3,092	3,092	627,754	
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)			3,092	3,092	627,754	
21 COST TO BE ALLOCATED			11,487	19,901	95,355	
22 UNIT COST MULTIPLIER			3.715071	6.436287	0.151899	

HHA COST CENTER	ADMINISTRATI VE & GENERAL (ACCUM. COST	OPERATION OF PLANT (SQUARE FEET	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY	HOUSEKEEPING (SQUARE FEET	DIETARY (MEALS SERVED	CAFETERIA (MEALS SERVED
	6	8	9	10	11	12
1 ADMIN & GENERAL	126,743	3,092		3,092		400
2 SKILLED NURSING CARE	431,857					
3 PHYSICAL THERAPY	338,075					
4 OCCUPATIONAL THERAPY	62,810					
5 SPEECH PATHOLOGY	25,898					
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	7,405					
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	992,788	3,092		3,092		400
21 COST TO BE ALLOCATED	235,508	82,493		13,957		15,967
22 UNIT COST MULTIPLIER	0.237219	26.679495		4.513907		39.917500

Health Financial Systems MCRIF32
 ALLOCATION OF GENERAL SERVICE
 COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

FOR RED BUD REGIONAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)
 PROVIDER NO: 14-1348 PERIOD: 7/ 1/2007
 HHA NO: 14-7486 TO 6/30/2008
 PREPARED 11/25/2008
 WORKSHEET H-5
 PART II

HHA 1

HHA COST CENTER	NURSING ADMINISTRATION (NURSING SALARIES 14	CENTRAL SERVICES & SUPPLIES (COSTED REQUIS. 15	PHARMACY (COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY (GROSS REVENUE 17
1 ADMIN & GENERAL		9,314		1,595,957
2 SKILLED NURSING CARE				
3 PHYSICAL THERAPY				
4 OCCUPATIONAL THERAPY				
5 SPEECH PATHOLOGY				
6 MEDICAL SOCIAL SERVICES				
7 HOME HEALTH AIDE				
8 SUPPLIES				
9 DRUGS				
9.20 COST ADMINISTERING DRUGS				
10 DME				
11 HOME DIALYSIS AIDE SVCS				
12 RESPIRATORY THERAPY				
13 PRIVATE DUTY NURSING				
14 CLINIC				
15 HEALTH PROM ACTIVITIES				
16 DAY CARE PROGRAM				
17 HOME DEL MEALS PROGRAM				
18 HOMEMAKER SERVICE				
19 ALL OTHER				
19.50 TELEMEDICINE				
20 TOTAL (SUM OF 1-19)		9,314		1,595,957
21 COST TO BE ALLOCATED		2,098		17,599
22 UNIT COST MULTIPLIER		0.225252		0.011027

I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
 I 14-1348 I FROM 7/ 1/2007 I WORKSHEET H-6
 I HHA NO: I TO 6/30/2008 I PARTS I II & III
 I 14-7486 I HHA I

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:

COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS
PATIENT SERVICES							PART A
1 SKILLED NURSING	2	678,373	2	678,373	4,456	152.24	2,251
2 PHYSICAL THERAPY	3	531,059		531,059	4,110	129.21	2,216
3 OCCUPATIONAL THERAPY	4	98,664		98,664	655	150.63	414
4 SPEECH PATHOLOGY	5	40,681		40,681	200	203.41	103
5 MEDICAL SOCIAL SERVICES	6						
6 HOME HEALTH AIDE SERVICE	7	11,633		11,633	200	58.17	48
7 TOTAL		1,360,410		1,360,410	9,621		5,032

-----PROGRAM VISITS-----				-----COST OF SERVICES-----				
-----PART B-----				-----PART B-----				
NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR			NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR		TOTAL PROGRAM COST	
7	8	PART A 9		10	11		12	
1 SKILLED NURSING	1,182	342,692		179,948			522,640	
2 PHYSICAL THERAPY	1,139	286,329		147,170			433,499	
3 OCCUPATIONAL THERAPY	160	62,361		24,101			86,462	
4 SPEECH PATHOLOGY	47	20,951		9,560			30,511	
5 MEDICAL SOCIAL SERVICES								
6 HOME HEALTH AIDE SERVICES	60	2,792		3,490			6,282	
7 TOTAL	2,588	715,125		364,269			1,079,394	

LIMITATION COST COMPUTATION					PROGRAM COST LIMITS	PROGRAM VISITS
PATIENT SERVICES	1	2	3	4	5	PART A 6
8 SKILLED NURSING						
8.01 SKILLED NURSING						
9 PHYSICAL THERAPY						
9.01 PHYSICAL THERAPY						
10 OCCUPATIONAL THERAPY						
10.01 OCCUPATIONAL THERAPY						
11 SPEECH PATHOLOGY						
11.01 SPEECH PATHOLOGY						
12 MEDICAL SOCIAL SERVICES						
12.01 MEDICAL SOCIAL SERVICES						
13 HOME HEALTH AIDE SERVICE						
13.01 HOME HEALTH AIDE SERVICE						
14 TOTAL						

-----PROGRAM VISITS-----				-----COST OF SERVICES-----				
-----PART B-----				-----PART B-----				
NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR			NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR		TOTAL PROGRAM COST	
7	8	PART A 9		10	11		12	
8 SKILLED NURSING								
8.01 SKILLED NURSING								
9 PHYSICAL THERAPY								
9.01 PHYSICAL THERAPY								
10 OCCUPATIONAL THERAPY								
10.01 OCCUPATIONAL THERAPY								
11 SPEECH PATHOLOGY								
11.01 SPEECH PATHOLOGY								
12 MEDICAL SOCIAL SERVICES								
12.01 MEDICAL SOCIAL SERVICES								
13 HOME HEALTH AIDE SERVICE								
13.01 HOME HEALTH AIDE SERVICE								
14 TOTAL								

I PROVIDER NO: I PERIOD: I PREPARED 11/25/2008
 I 14-1348 I FROM 7/ 1/2007 I WORKSHEET H-6
 I HHA NO: I TO 6/30/2008 I PARTS I II & III
 I 14-7486 I HHA 1

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:

COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	PROGRAM COVERED CHARGES PART A
OTHER PATIENT SERVICES		1	2	3	4	5	6
15 COST OF MEDICAL SUPPLIES	8.00		5,879	5,879	26,879	.218721	11,933
16 COST OF DRUGS	9.00		119	119	325	.366154	
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES -----PART B-----		-----COST OF SERVICES----- -----PART B-----
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	NOT SUBJECT TO DEDUCT & COINSUR 10
			SUBJECT TO DEDUCT & COINSUR 11
15 COST OF MEDICAL SUPPLIES	14,946		3,269
16 COST OF DRUGS	325		119
16.20 COST OF DRUGS			

PER BENEFICIARY COST LIMITATION:	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UNDUP CENSUS FROM WRKST S-4		
16.01 PROGRAM UNDUP CENSUS FROM WRKST S-4		
17 PER BENE COST LIMITATION (FRM FI)		
17.01 PER BENE COST LIMITATION (FRM FI)		
18 PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.224878			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.168181			COL 2, LN 3
3 SPEECH PATHOLOGY	52	.404150			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.151468	38,811	5,879	COL 2, LN 15
5 DRUGS CHARGED TO PATIENTS	56	.366189	325	119	COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5	COST PER VISIT 2	----- PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE ----- ----- PROGRAM VISITS ----- PRIOR 1/1/1998 TO 12/31/1998 2.01 3	----- PROGRAM COSTS ----- PRIOR 1/1/1998 TO 12/31/1998 3.01 4	PROG VISITS ON OR AFTER 1/1/1999 5
1 PHYSICAL THERAPY	1	129.21			
2 OCCUPATIONAL THERAPY	3	150.63			
3 SPEECH PATHOLOGY	4	203.41			
4 TOTAL (SUM OF LINES 1-3)					

TITLE XVIII HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES
PART A

	1	PART B NOT SUBJECT TO DED & COINS 2	PART B SUBJECT TO DED & COINS 3
1 REASONABLE COST OF SERVICES		119	
2 TOTAL CHARGES		325	
3 CUSTOMARY CHARGES			
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
5 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			
6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)			
7 TOTAL CUSTOMARY CHARGES		325	
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST		206	
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES 1	PART B SERVICES 2
10 TOTAL REASONABLE COST		119
10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	836,249	452,605
10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES	3,084	3,974
10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES	1,190	
10.05 TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06 TOTAL PPS REIMBURSEMENT-SCIC EPISODES	4,981	2,578
10.07 TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.08 TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11 TOTAL OTHER PAYMENTS		
10.12 DME PAYMENTS		
10.13 OXYGEN PAYMENTS		
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS		
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12 SUBTOTAL	845,504	459,276
13 EXCESS REASONABLE COST		
14 SUBTOTAL	845,504	459,276
15 COINSURANCE BILLED TO PROGRAM PATIENTS		
16 NET COST	845,504	459,276
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	845,504	459,276
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21 OTHER ADJUSTMENTS (SPECIFY)		
22 SUBTOTAL	845,504	459,276
23 SEQUESTRATION ADJUSTMENT		
24 SUBTOTAL	845,504	459,276
25 INTERIM PAYMENTS	845,504	459,319
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE PROVIDER/PROGRAM		-43
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

TITLE XVIII HHA 1

DESCRIPTION	P A R T A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	3	4
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		845,504		459,157
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		NONE		162
ADJUSTMENTS TO PROVIDER				
ADJUSTMENTS TO PROVIDER				
ADJUSTMENTS TO PROVIDER				
ADJUSTMENTS TO PROVIDER				
ADJUSTMENTS TO PROVIDER				
ADJUSTMENTS TO PROGRAM				
ADJUSTMENTS TO PROGRAM				
ADJUSTMENTS TO PROGRAM				
ADJUSTMENTS TO PROGRAM				
ADJUSTMENTS TO PROGRAM				
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		845,504		459,319
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER				
TENTATIVE TO PROVIDER				
TENTATIVE TO PROVIDER				
TENTATIVE TO PROGRAM				
TENTATIVE TO PROGRAM				
TENTATIVE TO PROGRAM				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT				
AMOUNT (BALANCE DUE)				
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ____/____/____

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.